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ABSTRACT

This manual introduces some of the essential principles of counseling. It is geared toward the training and education of those who have not had significant prior counseling experiences and is not comprehensive. These topics are discussed, focusing on basic, introductory material: (1) general principles of human behavior and motivation including Maslow's hierarchy; (2) interpersonal relations; (3) listening skills; (4) identifying feelings; (5) self-knowledge; (6) historic distrust and the counseling of American Indians and Alaska Natives; (7) depression; (8) suicide; (9) philosophy and methods of helping alcoholics and substance abusers; (10) spouse abuse; (11) sexually oriented problems; (12) rape; (13) how to handle cases, illustrated with sample cases and appropriate responses; (14) rules for a healthy fight including listening, problem identification and problem solving, anger, brevity, timing, running away, misunderstanding, third party, and responsibility; and (15) a description and use of the mental health commitment law. Lists of Alaska regional mental health programs are given. A reading list on general counseling topics, family involvement, substance abuse, sexuality, personal self-awareness, depression and loss, and recommended reading is provided. (ABL)

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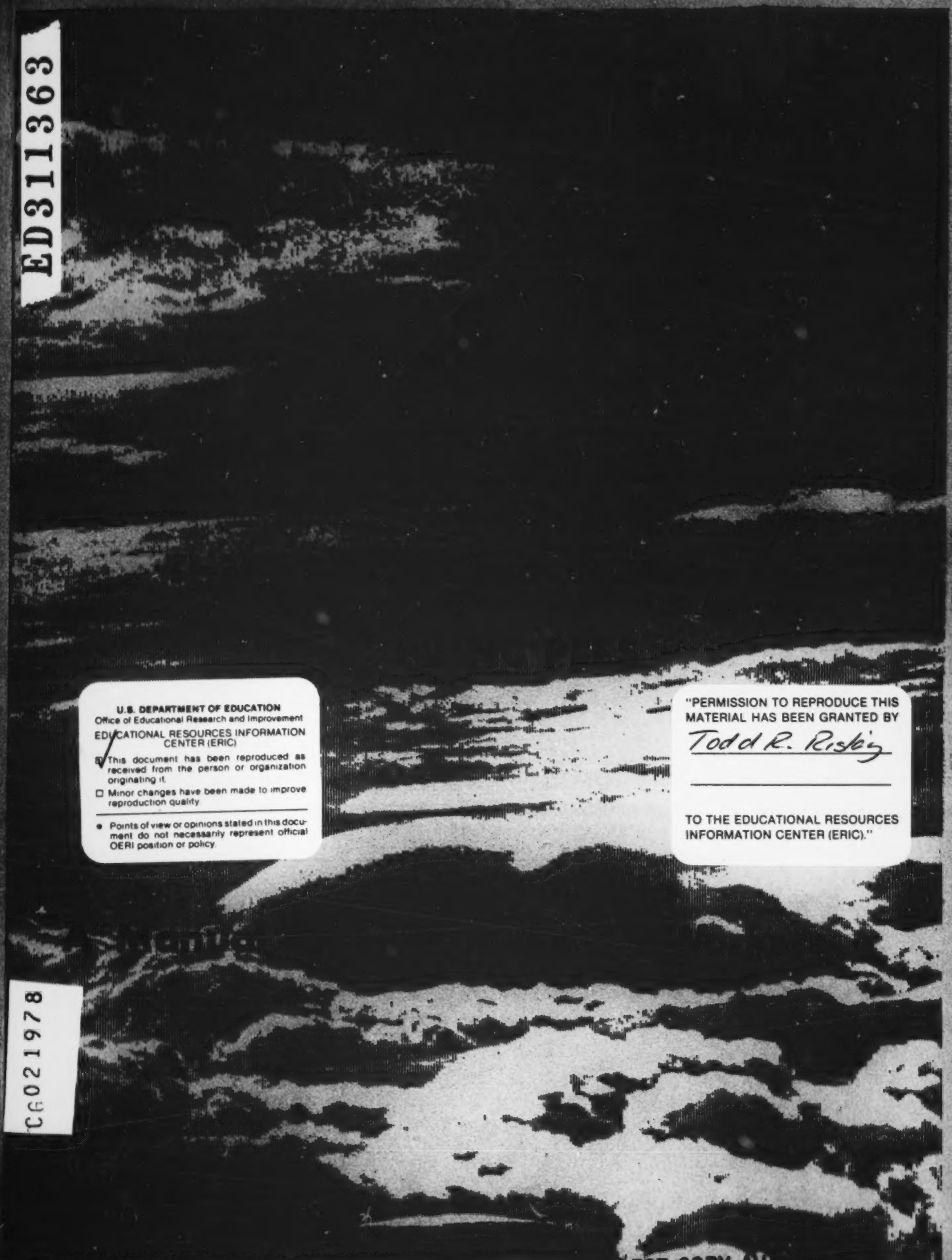

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INTRODUCTION TO THERAPEUTIC AND COUNSELING PRINCIPLES

A MANUAL FOR HUMAN SERVICE WORKERS

Produced by the
Department of Health & Social Services
Division of Mental Health &
Developmental Disabilities
Juneau, Alaska

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INTRODUCTION

The purpose of this manual is to introduce some of the essential principles of counseling. It is geared towards the training and education of those who have not had significant prior counseling experiences. It is by no means thought to be comprehensive. On the contrary, it is seen as introductory only, and in that sense we hope it serves to stimulate further study. The primary areas in discussion include (1) General Therapeutic Principles (2) Depression and Suicide (3) Substance and Sex Abuse (4) How to use the mental health civil commitment law.

Much of the material in this manuscript stems from the training manual utilized by the Suicide Prevention Crisis Center in Anchorage. We wish to thank this agency for allowing our use of this material.

We hope this manual is worthy of your time.

PRINCIPLES OF HUMAN BEHAVIOR AND MOTIVATION

From the many studies and theories of human behavior and motivation, five principles stand out as being particularly important in exploring why people behave as they do:

1. Behavior depends on both the person and their environment.
2. Each individual behaves in ways which make sense to him or her.
3. An individual's past experience influences their perception of a situation, which in turn influences their behavior.
4. An individual's view of himself or herself influences what they do.
5. An individual's behavior is influenced by what they need, which varies from person to person and from time to time.

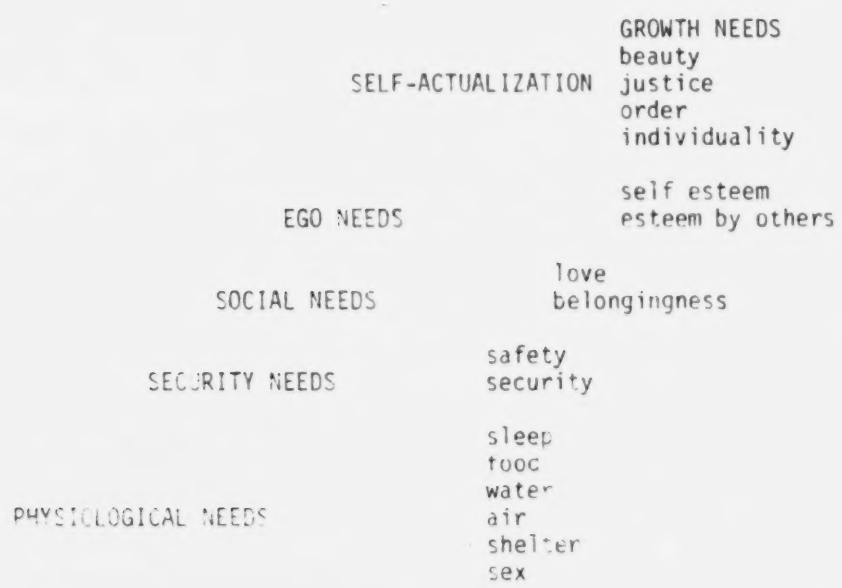
Now let's spend some time and develop these principles further.

Behavior depends on both the person and their environment. What a person does can be determined almost completely by their own skills and experiences, some aspect of the situation, or some combination of both. The latter is usually the case. Thus, if we want to understand and work effectively with others, we need to give attention to the individual, and to the situation they are in. This principle is particularly important to keep in mind when things go wrong. We tend to look for a "scapegoat" and we see this scapegoat as a person, rather than heeding the situation that person is in!

An individual's behavior is influenced by their needs. Our needs vary in a consistent manner. Needs vary from person to person and from time to time. One widely held view is that our needs are grouped according to various levels of accomplishment. This theory, supported by psychologist Dr. Abraham Maslow, has been used by many behaviorists to explain need structures of individuals. It is commonly referred to as "A Hierarchy of Human Needs," and gives insight

into the motivating factors in individuals. This "hierarchy of Human Needs" is briefly explained as:

1. PHYSIOLOGICAL NEEDS (basics of life) include those things which are important to sustaining life itself, such as food, water, activity, air, and sleep.
2. SECURITY NEEDS constitute a projection into the future of the physiological needs and include such things as protection from physical harm, assurance of continuing income, and continuing employment.
3. SOCIAL NEEDS include a sense of belonging, membership in a group, and acceptance by other people.
4. EGO NEEDS (self esteem) include things that reflect a sense of self-respect and self-confidence on the part of the individual.
5. SELF-ACTUALIZATION (top of hierarchy) refers to a sense of accomplishment and the development and utilization of one's potential capabilities.



We show these needs in an ascending order to indicate a progression from one level to another. A need at one level tends to come into operation as needs at a lower level are satisfied. So, if we take into consideration the need level that a person is at, their behavior patterns and the factors that motivate them can be somewhat determined. For example, we become concerned with food when we are hungry, drink when we are thirsty, and so on until that need level has been satisfied so that we can progress to the next level of needs. Or to put it another way, once we are full, additional food does not become a motivator, and our interest turns to other things. Someone has said, "one lives by bread alone - when one has not bread."

INTERPERSONAL RELATIONS

ACCEPTING FEELINGS

This training is concerned with the ways people relate to each other. We will say that two people are relating when each is responding to the other as a person. It is possible for people to respond to each other as objects. An example of this would be asking someone for the time a day. You might have consulted a clock just as well.

The most important difference between objects and people is that people have feelings. No matter how obvious this sounds, it is the one thing which is easiest to forget.

People tend to talk about facts and ideas rather than about their feelings; to avoid silences during conversations if they can; and to show more agreement than they really feel for the sake of good-will. Are most of your conversations with people like this?

These tendencies are not necessarily bad. However, they are part of a general pattern of human relationships in our society. When carried to extremes, this pattern keeps people from being human with each other. In short, it turns people into objects.

A feeling is something that a person feels, such as fear, restlessness, joy, anger, contentment, uneasiness, affection, etc. This is different from an opinion or belief.

A very important part of relating to other people is the ability to let someone know you are aware of their feelings, and to do it in a way that does

not make them wish they had kept their feelings hidden. When this is done successfully, we call it showing acceptance of their feelings.

Showing acceptance of a feeling does not necessarily mean doing something about the feeling, such as giving advice, giving reassurance, or even saying that you think the feeling is justified.

When you recognize another person's feeling, it is easy to say something that might make them feel foolish, ashamed, or inferior, and to do this without realizing it. Such a response may show that you are aware of the feeling, but it is likely to make the person wish that they had kept it hidden.

People often find the concept of showing acceptance confusing because of the difficulty in separating it from other familiar ideas such as being courteous, diplomatic, helpful, etc. It is important to recognize that these other things need not be involved, although of course they may.

One way to show acceptance of a feeling is to refer to it by name, using words like annoyance, fear, affection, etc. When you show acceptance of another person's feelings, you let them know that you are aware of their feelings without making them feel foolish, ashamed, or inferior. You do not need to pretend that you agree with their opinion. It is quite possible to show acceptance even if you disagree. Accepting another person's feelings is telling them, in a sense, that you know what they are feeling and that it is alright for them to feel that way.

Looking at it from this point of view may help you to see the difference between showing acceptance and certain other ways of responding. For example: giving advice, giving reassurance, and showing strong agreement all may have the effect of discouraging, or cutting off someone's expression of a feeling, and thus they are not the same thing as showing acceptance.

Giving advice often indicates an interest in the facts of the matter or in some problem, rather than an interest in feeling. It is important to be able to recognize when you are responding to facts or problems and when you are responding to feelings.

Of course, solving problems is one of the important goals of interaction with other people, particularly in a work situation. On the other hand, there are times when a problem cannot be solved effectively because it is necessary to deal first with the feelings which are involved. A good response to a feeling often refers to the feeling by name, using words like: disappointment, annoyance, anger, etc.

Frequently, when people become aware of anxiety or fear in someone else, they think that in order to be accepting, they must give reassurance by saying something like, "Everything will be alright." Actually, reassurance may not show acceptance at all. It can show a lack of interest in the person's feelings, and will often imply that their fear is unfounded and wrong. Showing acceptance does not mean that you have to do something about the feelings. Two kinds of responses which are often made with the kindest intentions, but which nonetheless can sometimes have the effect of cutting off or discouraging the expression of feelings, are hasty advice and glib reassurance.

Just as reassurance and advice can be used in ways that do not show acceptance, the same thing is true for agreement, particularly vigorous agreement.

OWNING FEELINGS

When you show acceptance of someone's feelings, it helps him or her to accept them. Similarly, if someone shows acceptance of your feelings, it

will help you to accept them yourself. Acceptance of your own feelings, which is an essential part of self-respect, is not always easy to attain. Gaining awareness of your own feelings can be a step toward increased self-acceptance and self-respect.

One of the things that you can do to gain greater awareness of your own and someone else's feelings is to cultivate the habit of focusing on them. When you focus on something, you turn your attention to it. This usually means that you are turning your attention away from other things at the same time.

It is important to appreciate the difference between having a feeling, expressing it, and acting on it. There are times when it would not be appropriate to act on a feeling, although it would be alright to express it. At other times it might not be suitable to even express a feeling; but it is never wrong to have a feeling or to be aware of it.

Let's examine a notion which we call owning your feelings. Owning a feeling implies that you are aware that the feeling belongs to you, and that it is different from the outside events which may have provoked it. In contrast, disowning a feeling involves talking about something outside yourself - some object or some other person. Expressing a feeling in this way:

a. tends to confuse the feeling with something else,

b. requires that the listener infer that you have the feeling since it is not acknowledged directly,

c. tends to turn the focus of attention away from yourself and your feeling, and

d. leaves you an opportunity to deny it if you think that someone doesn't like it.

When someone expresses negative feelings accusingly to you in a way that focuses on you and your behavior it is difficult to respond constructively. You may want to justify your actions and also make them stop having their feelings. Would you be likely to show acceptance of their feelings? No.

Owning feelings is important not only because it helps you to gain a fuller understanding of them, but it usually has a favorable psychological effect on you. This is reflected in expressions such as, "It felt good to get it off my chest."

People sometimes worry that once they start being open, they will not be able to be cautious when it is necessary, but this is not true.

Some kinds of disowning feelings leave you an escape. For example, if someone felt very uneasy but was not sure that you would show acceptance of their feeling, they might say, "This is the kind of situation that might make you uneasy."

Expressing a feeling by accusing usually shows an attempt to justify the feeling at the same time you reveal it. An example might be: "Anyone would be enraged by what you just did! It was a very cruel thing to do." This protects you by focusing on the other persons' actions rather than on your own feelings.

One of the reasons that people express negative feelings accusatively, instead of owning them, is that the accusation usually sounds more objective. In a sense, an accusation covers up the fact that the speaker's personal feelings are involved. When you accuse someone, the listener responds to the accusation and tries to defend against it.

Sometimes the difference between owning your feelings and expressing them by accusing is simply the difference between using the word "I", or using the

word "you". When argument starts, owning feelings stops. The words center around events, authoritative statements, logical deduction, and so on, but not around feelings. Argument is characterized by trying to change the other person. Owning involves letting the other person know something about yourself.

There is nothing wrong with trying to change another persons' opinion, but in an argument there is a feeling or implication that they must change if you are going to keep liking each other.

One of the most damaging things about arguments is that we go to such great lengths to avoid them. Denying your own feelings to hide disagreement is a big price to pay. Actually, you do not need to pay this price since it is possible to express negative feelings or disagreement without arguing. It is true that disagreement and negative feelings often do lead to arguments. This is particularly true if the feelings are expressed by accusing. However, the likelihood of argument can be reduced if you do <u>not</u> make it sound as if you are blaming or accusing some <u>other person</u>, but instead make it very clear that you are talking about <u>yourself</u>.

If you believe that it is wrong for you to have certain feelings, it will be almost impossible for you to examine those feelings and to gain a full awareness of them. Therefore, it is important to remember that <u>having</u> a feeling and <u>acting</u> on it are two different things. It might be inappropriate to act on certain feelings, but it is <u>never</u> wrong to have them.

SELF-CONCEPT

Everyone has an image of oneself as a person. This is called a self-concept. If you see yourself as a warm, loving person, then this is part

of your self-concept. You might also think of yourself as being irritable and nasty; this too, would be part of your self-concept. A persons' self-concept is how they see or think of themselves.

Everyone also has an idea of the kind of person they would like to be. Everyone has these concepts of themselves. Generally, such ideas are quite definite and fixed, although you may not realize this until you stop to think about your own self-concept and self-ideal.

It is possible to say that you would like to be different in certain ways, and still not blame yourself for being what you are now. However, it is very difficult to keep these things separate, so all too often what you would like to be gets confused with what you think you should be.

The term self-acceptance is a little misleading because it is often taken to mean that you are satisfied, or that you are resigned to being the way you are. Actually, it means that you do not dislike yourself for BEING what you are.

There is an even more important aspect of self-actualization which is much harder to identify. This is one's motivation for a more meaningful and fulfilling life, and the wish to be closer to others and to share ourselves with them. Probably the best way for most of us to achieve greater self-actualization is through inter-personal relationships.

Each person has their own self-concept and their own self-ideal. The fact that people are different in this respect, and in other respects, should not interfere with the relationship between them.

During most of your normal day, there are probably very few times when you feel it is safe to show feelings openly. As a result of this, you usually don't have a chance to become fully aware of your feelings, or to understand them.

One of the main goals of this training is to provide a setting in which you can feel more open about owning feelings, and can thereby gain in self-awareness and self-understanding. Naturally, this setting cannot exist without the cooperation of you and your partners. Through the experience you gain here, you may find that there are more times when it is safe to own your feelings than you thought.

In a given situation you might be aware of only one feeling, but you are usually experiencing several feelings. It is difficult to be aware of more than one feeling at a time, particularly if you are experiencing feelings which seem to be opposed to each other. There is one case in particular where people may experience two feelings at the same time. This is the case in which someone has a feeling and also feels concerned about another person's reaction to this feeling.

When someone expresses a negative feeling by accusing, this usually indicates that in addition to the negative feeling involved, there is also some feeling which makes them reluctant to own it. Naturally, there are some situations where it is not safe to express negative feelings at all. You are the best judge of those situations, and we are not advocating that you start being open about your negative feelings all the time. However, there are also some situations in which you can express negative feelings, or may even have to. In such situations, the results are more likely to be favorable if you express the feelings by owning them, instead of by accusing.

People often experience a basic increase in awareness of feelings, but only later begin to interralize the concept of showing acceptance. Thus you would become more alert to someone's feeling before you have gained the knack of letting them know that it is alright with you for them to have the feelings. How true is this for you?

It is our hope that the instruction and experience provided by this training will enable you to achieve more and more growth-producing experiences in the future, so that this will be a continuing process for you. It is through such relationships that you can gradually internalize the concepts which lead to greater self-understanding, greater self-acceptance, and thus a greater self-respect.

LISTENING: A SUCCESSFUL THERAPEUTIC APPROACH

Listening is an art requiring knowledge, effort and understanding. Many people think they are listening when they are just hearing. Hearing is merely the reception of stimuli over auditory pathways.

Listening is a major component of communication. Seventy percent of an individual's conscious waking moments are spent in verbal communication. Of this communication time, about 16% is used in reading, 30% in speech and, amazingly, 45% in listening. Unfortunately, without special training, the average person has only a twenty-five percent listening efficiency. Most of us, instead of listening, are simply quiet until the other person stops talking - if we wait that long!

Listening benefits both the speaker and the listener. The listener contributes to the comfort of the speaker by allowing them to discharge their tensions or talk about their feelings, since talking is the most common way of ventilating feelings. The listener also gives confidence to the speaker by giving of their time and attention. In turn, the speaker actually values the company of the listener. The disciplined listener is not only popular but also learns about the subject being discussed and about the person speaking. Listening helps solve mutual problems and leads to better cooperation between people.

THE ART OF LISTENING

The good listener is a combination of two primary types, the intellectual or logical kind who listen with their heads but deny their real feelings, and the emotional or over-anxious type who listen almost entirely with their feelings.

The good listener, acquiring both of these characteristics to a degree, will convey their interest in other people, and a willingness to foster confidence and understanding. The good listener stimulates the speaker to search their mind for useful material and organize this material so that is moves toward an objective.

Listening assumes three levels of mental activity. One is the hearing level in which the person being spoken to does not listen at all. Another is the level of hearing. Here the one spoken to remembers the words being said and can repeat them, but there is no real absorption of ideas. Finally, there is the level of thinking the listener thinks about what is being said. Thinking about something means doing mental work on it, comparing it with something else, analyzing its cause, predicting likely outcomes or making a decision about it. In order for a person to transfer their ideas into the mind of the listener, the listener has to be using this level of thinking with the thoughts being conveyed through a mutually understood language. Anything less than this is merely talking rather than an interchange of ideas.

<u>The act of listening is often more helpful than any words of advice</u>. Opportunities for constructive listening come to everyone, but the actual art of listening must be learned.

The prospective learner must first acquire discipline and patience to listen effectively. They must also have concentration. Many of us have difficulty with this because we take particular pride in doing a number of things at one time. For example, don't we consider the homemaker quite accomplished if he or she can talk on the phone, peel vegetables, follow a television serial and talk to their children at the same time?

Lack of concentration in our society is also prevalent because we are afraid of being alone with ourselves.

Finally, a good listener must possess comprehension, or understanding of the true idea or meaning of what is being said. Comprehension is not found in the words spoken but in the meaning given them by both sender and receiver. It is difficult to comprehend because we think faster than we talk. We speak at the rate of one hundred and twenty-five words a minute but we think four times that fast. What an individual does with this extra time makes them either a good listener or a poor one.

TEN COMMANDMENTS FOR LISTENING

The ten commandments for listening are:

1. Stop talking - be attentive.
2. Put the individual at ease by creating an accepting environment. Do not be shocked.
3. Remove distractions - receive the individual in a private setting.
4. Be determined to see the individual's point of view - reduce interruptions, resist quick diagnosis.
5. Listen to understand, not to reply. Do not hand out advice, solutions or answers too soon.
6. Be patient; do not cut off too soon.
7. Hold your temper; accept the person as they are.
8. Go easy on criticism - be tactful.
9. Ask questions that show your interest.
10. Stop talking again.

GENERAL SUGGESTIONS

1. Be yourself, don't attempt to play a role, use your own familiar delivery. When you really want to help, the individual will know it and

you will convey the feeling that you are with them and you are interested in them. Speaking slowly, in a calm, soft tone of voice will help you convey your message.

2. Help the individual tell you what they want; don't master-mind the case. It is better to know nothing and to allow the person to develop their problem personally by verbalizing it to you.

3. Get acquainted by listening. Listen to what they are telling you, not recessarily to what they are saying. The individual's communication may be initially confusing. Do not lead them on by pretending you understand when you don't. You can ask questions that will help clarify the issues for both of you. As you listen, verify your impressions. Test your impressions in several ways:

Ask for clarification: "I'm not sure what you mean," "I don't follow you, can you put it a different way?" The need for clarification can be indicated simply by repeating the crucial word or phase with questioning inflection as in the following example: "Joe was an unfit manager." "Unfit?" "Yes, he totally lacks planning ability and foresight."

4. Help the individual to the point where they say, "This is my problem, this is what I am having difficulty with." Then, work slowly, relax and go slow. Give the individual time to interact and accept their share of the responsibility.

5. Make sure you understand the other person's inner state. When somebody speaks, you notice more than the words they use. You note their "tone of voice", "style of speaking", and you evaluate their emotional state. You draw conclusions about their inner state using these factors. Your inferences lead you to perceive the other as "angry", "pleased", "hurt", etc. Your perception may be inaccurate and should be checked out for

two reasons:

a. to avoid acting on false assumption and incorrect understanding.

b. to indicate your concern for their feelings and your desire to understand them as a person.

Examples: You may say, "I get the impression that you are very angry, are you?" or "You sound upset, can you tell me about it?"

6. A number of general responses which will allow the individual to think through for himself or herself are as follows:

How do you suppose it will work out?

What are the other possibilities?

What you you tried thus far?

What if that doesn't work?

What do you think is best?

Can you give me an example?

How does it look right now?

Let the individual answer their own questions. Don't put your own words in their mouth.

7. After identifying the problem, and after you feel you understand it, you may work out procedures for dealing with the problem. Do not be overly afraid of making mistakes. Play it by ear and you will learn how to be effective.

8. Listen and verify their feelings and understanding of any suggestions you make. Be aware of any new problems which may arise at the close of the conversation. You might ask, "Do you think this will be of help, is this what you want?" In this way, you can get a commitment from them and you help them take the next step, which is to get in touch with the

appropriate agency or try out some of the alternatives that were decided upon.

9. Be careful not to become over identified with any one solution. Present the good points, look at some of the drawbacks, and do this in a way that both of you can discuss, question, reject, or accept the suggestion without either of you having to reject the other.

10. There is no set time limit for a problem solving session. Each will require a different amount of time depending on the problem. Initially, line workers seem to attempt to find "quick solutions". As they become more at ease they become more skillful in gauging the appropriate length for a particular situation and in knowing when to guide the individual toward a solution, referral, termination or return for another conversation.

SUMMARY OF LISTENING GUIDELINES

1. Initiate Involvement
   - --friendly, accepting, greeting
   - --responding to, and recognizing feelings
   - --use your voice to help and listen
   - --take time to develop rapport
2. Get Details of Distress
   - --explore nature of problem
   - --encourage person to be specific and personal
   - --watch for off-track, off-balance, over-diagnosing
   - --discover other efforts to get help
   - --summarize problem, get a commitment to find answers
3. Begin a Plan of Action

--don't rush in with advice

--focus on a problem with which you both agree

--explore alternatives and resources

--agree on a plan of action for both

--make referrals sensitively

--don't promise what you can't deliver

--encourage return visits when necessary

--review listening guidelines

GREETING THE INDIVIDUAL

Greeting the individual properly is important because their response to your greeting may determine how willing they are to stay on and share their problems with you. Many people leave after the first visit. They may lose their nerve or may be testing how understanding you sound.

Individuals usually will respond to your greeting with a message about how they're feeling or what's bothering them. You want to open them up and invite them to say more about how they are feeling. The best way to do this is to send them an open ended question or statement. Here is an example:

Worker: What can I do for you today?

Individual: It's my wife, she never talks to me anymore.

Worker: Why don't you tell me more about it?

Some other appropriate responses to individual's initial statements of feelings or problems are:

"I'd like to hear the whole story."

"Would you like to talk about it?"

"It sounds like this is really important to you."

"I'd like to listen and help if I can."

IDENTIFYING FEELINGS

Once the individual begins expressing his/her feelings you must identify these feelings in your mind. Identifying feelings will help you listen accurately to how the person feels. It will also help you when you begin to feed back (reflect) the feelings and content of the individuals message. You can identify feelings by:

1. Finding synonyms for feelings the individual expresses.
2. Using situational cues.
3. Using inflectional cues (tone of voice, emphasis, etc.)

Synonyms are some words that mean about the same thing as the feeling expressed by the person. Here is a list of "feeling words". Find synonyms for them.

Depressed_____/_____/_____

Confused_____/_____/_____

Worried_____/_____/_____

Contented_____/_____/_____

Hopeful_____/_____/_____

SITUATIONAL CUES

In using situational cues to identify feelings you will have to reach back into your own experience in a similar situation. Or a situation may evoke a universal emotional response. For example, if a individual said,

My grandfather died," you think that he is probably feeling sad, grief-stricken, mournful.

When using situational cues you must be careful not to jump to conclusions too quickly because different people respond to situations differently, and more data from the individual may alter your perception of a individual's feelings. Also, any given situation may evoke more than one emotion, even several opposing feelings.

In the case of the individual who said, "My grandfather died," his statement tells you he is probably sad, grieving, and mourning. As he talks, you discover his grandfather died after a long, painful illness. Now you might assume he is also relieved. Suppose his family has been relying on him to "hold things together." He may feel tired and burdened, or on the other hand, strong or proud of himself, depending on how he reacts to his family's reliance on him.

INFLECTIONAL CUES

Inflectional cues include the tone of the individual's voice, the rate of speech, loudness, pauses in speaking, signing, and emphasis. Inflectional cues will help you qualify feelings, discover the intensity of feeling, and find the most accurate definitions for feelings.

Say to yourself the following phrase in ways that would convey that you were: relieved, happy, depressed, angry, disappointed, and proud. "I got a 'C' on that test." Practice saying the phrase until you're satisfied that you accurately convey each of the feelings in turn.

Finding a speaker's meaning by attending to inflectional cues comes so naturally to you that you don't realize you're doing it. Here are some

generalizations about inflectional cues, but you will have to learn the subtleties by experience.

1. People who are excited, anxious, afraid, or angry may talk FASTER than usual.
2. Someone who is disappointed, dejected, depressed, lonely, or hurt my talk SLOWER than usual.
3. People feeling angry, happy, proud, or frustrated may talk LOUDER than usual.
4. People who feel depressed, hurt, or lonely may talk SOFTER than usual.
5. Someone who is unsure of what they want to say, is shy, or embarrassed may PAUSE or HESITATE a lot.

REFLECTING FEELINGS AND CONTENT

REFLECTING FEELINGS

Is feedback to the caller in terms of precise, clear descriptions of the emotions he or she is expressing either overtly or implicitly.

REFLECTING CONTENT

Is feedback of the source (situation, event, or person) of the person's feelings. Reflecting feelings and content are usually done together, i.e., "You feel_____because_____.

For example:

Client: My husband left a week ago. I ache all over. It's so lonely here without him. What am I going to do?

Worker: "You're feeling lonely and hurt because your husband left."

Your parts of this model can be arranged in any order. for example: "Because your husband left, you're feeling hurt." Or, "You're hurt because your husband left."

Be careful you don't feed back the client's words instead of the essence or meaning of the message. Reflecting the caller's exact words is called PARROTING. Parroting the woman in the above example would sound something like this: "Your husband left you a week ago, and now you ache all over and feel lonely. You don't know what to do." A better reflection of this caller's feelings would be: "Now that he's gone, you feel hurt and alone. You're uncertain about what to do next." The words hurt and alone are synonyms for the caller's words "ache all over". Uncertain describes the lost feeling evident in her question, "What am I going to do?"

Your task as a listener is to try to understand what individuals are feeling or what their messages mean. Then you put your understanding into your own words and feed it back (reflect it) for the individuals verification. You do not send a message of your own, such as evaluation, opinion, advice, or question. Feed back only what you feel the individuals message meant--nothing more or less.

If you are reflecting the essence of the messages, uncontaminated by your own opinions, the speakers' will unfold before you. You will hear exactly how they feel and what is causing them to feel that way. As you reflect the meanings they give you, they will begin to have a fuller understanding of themselves and their problem situation. They will be glad they've found someone who really listens and who understands what they're going through. (The individual knows you're listening to them and understanding because you are reflecting the meaning of the messages they send.)

Once they realize you're attending carefully to what they say, clients can talk freely and openly about what's troubling them. Since you are not offering opinions or advice, not putting them down or judging them, they need not be afraid to be honest with you and themselves.

SUMMARIZING RESPONSES

Summarizing responses is an attempt to review, condense, or clarify what the person has said. It is similar to reflection of feelings and content, except that it covers a longer period of time and more caller input. Summaries are often used in the following situations:

1. When the individual's presentation has been lengthy or confusing;
2. When the individual has apparently expressed everything he/she wants to on a particular topic;
3. When mutual assessment and agreement are needed before moving on (especially helpful before goal-setting;
4. At the end when the listener wants to emphasize what has transpired and been learned from it.

PROBLEM SOLVING

Problem solving is a systematic way to attack and eliminate (or minimize) conflicts clients are experiencing. Problem solving includes the following six steps:

1. Defining the problem
2. Setting a goal
3. Generating alternative solutions

4. Evaluating the alternatives

5. Selecting a solution

6. Ending the session

Problem solving should take place only after you have fully explored the person's feelings about the situation she/he is calling about. It is tempting to assume you know what the problem is at the beginning of a session and to jump in with some solution.

You must give the individual time to tell you what's happening and how they're feeling. Reflect and summarize their messages to make sure you have a common understanding of the situation. Then you will be ready to help the individual define and solve the problem.

DEFINING THE PROBLEM

In defining the problem you try to help the individual discover exactly what problem, situation, or conflict needs resolving. If you have summarized large portions of the feelings and content of the conversation you will have some good clues as to what the central issues in the person's situation are. When the individual seems ready to begin resolving the conflict or when they have apparently said everything they want to about the situation, you should state, as simply as possible, what you think the problem is. If the individual agrees, you are ready to help them set a goal. If they disagree, you must explore the situation further and ask what they see as the main problem.

SETTING A GOAL

Goal setting is deciding what the individual wants to do about the problem. A goal is an objective, a result the individual wants to achieve. Most of the time you can get the person to set a goal by asking:

What do you want to do about this problem?

If you could change the situation how would you like it to be?

How will you know when this problem is solved?

Goal setting for a young man whose sister destroys his possessions might sound something like this:

Individual: "If you could change your situation how would you want it to be?"

Worker: "She'd stop getting into my stuff, leave it alone you know."

Individual: "So your goal is to keep her entirely away from your things."

Worker: "Yeah."

There are other possible goals for a person in this boy's situation, but he has chosen the goal that best meets his own needs, and you as the listener should help him try to meet his goal by helping him generate, evaluate, and select solutions to his problem.

Once you and the person understand the goal you are ready to engage in generating alternatives.

GENERATING ALTERNATIVES

Generating alternatives is helping the individual find additional ways of achieving their goals. Just as there are many routes you can take to get from one place to another, there are many alternative solutions to a problem. You should try to elicit as many alternatives from the individual as possible,

adding to the list those that they may not have thought of. When people are in a state of crisis they often think of the extremes--live or die, keep the status quo or make a drastic change. You should help the person fill in the list of alternatives with middle-ground, compromise, or combination solutions until they have a continuum of alternatives from which to choose.

You should help the individual list several alternatives even if you think some are less desirable than others. The individual owns their problems and has the right to consider every possible solution. Let the individual eliminate those that don't appeal to them from as complete a list you can create, together.

When you are generating alternatives, the individual may not be aware of the process you are trying to engage them in. They sometimes assume you have only one suggestion for solving their problem if you begin listing alternatives without explaining what you're doing. Also, if you list alternatives first, they may assume that you are in control and are going to take the most active role in problem solving.

You often can orient individuals to generating alternatives after they have stated a goal and you have verified it by saying something like:

"Now that you have decided what you want to do, let's try to think of some ways you might be able to accomplish this."

Or:

"There are probably quite a few ways you can solve this problem. Let's list a few and then you can choose one to try."

Or:

"How do you think you might be able to solve your problem?"

Here is an example:

Worker: "There are probably some different ways you can try to solve your problem. Let's try to think of some possibilities and then you can decide what you'd like to try."

Individual: "Okay."

Worker: "First, can you think of any ways to keep your sister away from your valuables?"

Individual: "I could move out of the house, or make her pay for everything she breaks. I could smash her face in the dirt, but that wouldn't be too good...I might threaten to tell the folks she is doing something she doesn't want them to know."

Worker: "I'm writing this down so we can remember them all. Can you think of anything else?"

Individual: "I wonder if I could put a lock on my door. I've run out of ideas."

Worker: "I can think of a few more. You might be able to get through to her by having a third party like a relative or counselor, talk with both of you. Maybe you could bargain with her--offer her something she wants in exchange for keeping her hands off your stuff. You could help her find a part time job so she can buy some things of her own. You might write her a letter explaining how you feel, since talking doesn't work. Can you think of any others?"

Individual: "Not really."

EVALUATION OF ALTERNATIVES

your door?"

Individual: "Well, it'd be cheap and I'd be sure to keep her out of my room. It'd stop all the hassling, too. I'm not real sure all my stuff will fit in my room. I guess all the most expensive stuff would, though."

Worker: "It sounds like the lock might be a possibility. What about talking to a relative or counselor?"

Individual: "Well, my uncle might be able to help. He was a counselor. I'm not sure she will go along with it, though. She's got me by the tail."

Worker: "She has most of the control in this situation, and you're not certain she'll be willing to help solve the problem."

Individual: "Yeah, and I'm afraid to offer her something for keeping hands off. It might give her even more power than she already has."

Worker: "The last thing on our list is writing her a letter. What do you think about this?"

Individual: "It might be a way to tell her what I want after I decide what to do, but it won't work by itself."

Worker: "Let's see if I can summarize all this. Making her pay for breakage will only work if you find some way to collect. The lock would be an easy way to keep her out, but it's hard to keep everything in one room. Your uncle could probably help work it out if only you could get your sister to talk with him. Paying her off would leave her in control, and a letter will only work as a means of telling her your decision."

SELECTING A SOLUTION

Helping the individual select a solution involves assisting them in choosing alternatives to try from a list you have narrowed down together by process of elimination. You can discuss each of the few solutions left and let the individual try to determine which one (or combination) seems most likely to achieve the goal. Often people can decide what to do after you have summarized the list, but sometimes you must help them re-evaluate the alternatives that are left. Sometimes a combination of two or more alternatives will work.

Worker: "Of the alternatives that are left, is there one that seems most workable?"

Individual: "Well, the lock's a pretty good idea!"

Worker: "You want to put a lock on your door, then?"

Individual: "Yeah, but I want to make sure she knows why I'm doing it and isn't offended by it. Maybe I should write her a letter, telling her how I feel and why I'm doing it. We might be able to avoid another hassle."

Worker: "You'd like to avoid a big fight about this, and you want her to know exactly how you feel. You think telling her in a letter may give you a chance to do this."

Individual: "Yeah."

SUMMARIZING

The main purpose of summarizing is to give the individual a feeling of movement in exploring ideas and feelings, as well as awareness of progress in learning and problem solving. Summarizing also helps to finish an interview on a natural note, to clarify and focus a series of scattered ideas, and to

clear the way to go on to a new idea. It permits the person to put the pieces together. Summarizing has the effect also of reassuring the person that you have been tuned into their messages all along. For the listener it serves as an effective check on their accuracy in receiving the full spectrum of the individual's messages. Summarizing the previous sessions at the beginning of the interview often provides needed continuity.

The helper tries to get the person to do the summarizing, if possible. This is a test of the person's understanding as well as being a method of keeping responsibility on them. The listener may say, for example, "How does our conversation look to you at this point? Try to pull it together briefly." In terminating a relationship it is likely that the summarizing will be a joint effort to capture the essential points explored, progress achieved, and the next steps planned.

ENDING THE CONVERSATION:

Ending the talk appropriately is important. You want the person to leave the conversation with a good feeling, whether or not their problem is completely solved. You should try to end the talk on a positive, friendly note which will make it easier for the person to contact you again if necessary. You may show interest in the person by asking them to return to let you know how the situation is working out. It is appropriate to end the communication in the following situations:

1. Problem is completed; individual is satisfied.
2. Problem is not completely solved and communication is going in circles.
3. Person is satisfied with the list of alternatives but is not able to make a choice at that moment.

4. Person has decided to discuss the problem with a professional helper or seek assistance from some other resource.

Some ways of ending a talk are described here:

1. Letting the person end the talk. "I guess I've talked myself out. We didn't solve anything, but it felt good just to talk to someone. Thanks a lot."
2. Summarizing what has happened during the talk. "Well, we've talked about a lot of possible solutions, and you've narrowed the list down to two, dropping the course or hiring a tutor. Since you can't decide which to do right now, why don't you think about it a while and come back if you need more help?"
3. Stating the degree of progress: "We've talked about your feelings about your husband's drinking, but you still seem confused by it all. Perhaps you need some time to think everything over. Maybe you'll want to come back and talk it over again."

GUIDING QUESTIONS

After establishing the necessary amount of "fact finding" about a specific problem, or situation, you should get answers to the following questions.

1. What is the immediate problem?
2. What is the level of danger presented by the situation? Is there a high risk of injury or even death? Does the problem require immediate action or can it wait?
3. Is there someone immediately available to help the person? A close friend, relative, etc.

4. What other resources are available?

5. Has the individual ever been in a similar situation, and if so, how did they deal with the situation then?

6. Is there an agency with whom the individual is involved? Could this agency be involved now?

7. Would the person be willing to keep you informed of their progress?

In a nut-shell, deal with feelings first and problem-solving will follow. The feelings will often define both the problems and their solutions. Ask yourself:

Do I have the right attitude toward the person?

Do I have a personal concern for what the person is talking about?

Does the individual sense that I care?

Do I seek to understand the problem?

Do I keep interrupting?

Do I convey to the individual their worthfulness as an individual?

Do I project judgemental attitudes?

Do I give attention?

Do I follow through on what I say?

Do I want assistance or aid from another listener?

SELF KNOWLEDGE

There are four primary painful emotions that most individuals feel intermittently through their lives. These painful emotions are depression, anger, fear and guilt. It is very important to deal with these feelings in a healthy way because if this is not done there may be destructive consequences. The following discussion is to help clarify how to deal with these emotions in a constructive way; and to demonstrate how these emotions can become sources of destructive behaviors if they are not dealt with in a constructive way.

To experience depression, fear, guilt or anger is normal, natural, healthy and intelligent. These emotions occur at specific times in an individuals life and are related to various circumstances that elicit or bring out these particular feelings. It is very important to understand that these emotions are normal. It is important to be able to identify and label these feelings correctly and then to be able to utilize them in such a manner that problems can be identified and solved. For example, if a person has lost a close relative and they are feeling fear or depression because of it, it would be most important for that individual to understand that he or she is experiencing fear and depression and to know that it is normal to have these feelings.

If on the other hand, these feelings are not identified correctly, the individual may be terribly frightened by them and start a process of running away from these feelings. People can run away from their feelings by engaging in excessive sexual activity, criminal behavior, violent acting out, substance abuse, or suicidal behavior.

It may be very difficult to deal with these feelings especially since two, three, or all four of them can occur in any combination at any time depending upon the particular circumstances or individual. If for example, all four feelings should hit at the same time and if that individual is not familiar with the process of dealing with these feelings, it is easy to see how they could become totally overwhelmed by such feelings. The individual would very likely use unhealthy mechanisms to kill the pain such as substance abuse, sexual acting out, suicide, or homicide.

The problem then becomes how to teach people to utilize these feelings in a constructive manner. If each individual learns how to deal with their feelings as they arise on a daily basis, they should be able to control their feelings and stay healthy and positive. It must be understood that if these feelings are felt and experienced fully; understood as natural, normal, healthy and intelligent; then an individual can use such feelings to identify their problems and even to find some solutions.

This process of finding problems and answers within feelings of anger, depression, guilt and fear can lead to self-knowledge. In other words, the individual learns about him or herself by dealing with feelings. Self-knowledge then leads a person to feel more in control of their own life. When the individual feels in control of their own life, this in turn leads to a feeling of well-being. So one might say that to feel these four painful emotions when they occur is to begin the process of understanding the self, of knowing what the individual's problems are, and what the solutions are. It is this process that leads to knowledge of the self, which in turn leads to a feeling of control and well-being. It can be stated then, that these four painful emotions can in effect lead an individual to a feeling of personal

power as opposed to the disaster of self-destruction. The critical difference between gaining personal power or destroying the self lays in learning how to process painful emotions correctly, as opposed to letting those feelings over-power and destroy the self.

HISTORIC DISTRUST AND THE COUNSELING OF AMERICAN INDIANS AND ALASKA NATIVES

The establishment of trust in any counseling relationship is crucial. When counseling minority clients, and specifically American Indians, the issue of trust takes on added dimensions. Relations between American Natives and Anglo Americans throughout history have provided the foundation for a type of distrust that goes beyond one-to-one relationships. Historic distrust that has become vested in a people because of past problems, and continues to be reinforced through continued difficulties, can be very hard to address on both a personal level and in a counseling relationship. In order for a counseling relationship involving a Native client and an Anglo or non-Indian counselor to be effective, historic distrust must be recognized and dealt with.

The counseling of minority people has received a great deal of attention in the past few years. Most of that attention has dealt with the counseling of Blacks, Hispanics, Asians, women, etc. Native Americans and their relationship to the counseling process are a neglected subject. The success of any counseling relationship is based on many conditions: the counselor's skills, the client's priorities, the amount of time the client is able to invest. The amount of trust is especially important when Native American people are counseled. The counselor has to be able to not only provide an atmosphere conducive to trust on a one-to-one basis, but he or she must also be able to deal with the historic distrust the Native client may feel toward the dominant society and authority. If the counselor is unable to recognize this second type of distrust, they will be less effective, and possibly will lose the client.

It has been observed that minority clients drop out of counseling after the first session more often than do non-minorities. Apparently, the minority client is not getting something out of that first session that would help them return for continued counseling. It is possible that counseling is felt by the minority client to be irrelevant, inappropriate, and insufficient for meeting their unique needs. There is also the possibility that, since we define counseling as a process of interpersonal interaction and communication (verbal and nonverbal), termination of counseling sessions might be due at least in part to communication problems or breakdowns. Effective communication is essential to a productive counseling relationship, and without trust, communication will be limited.

TRUST IN THE COUNSELING RELATIONSHIP

The establishment of trust in any counseling relationship is crucial to the effectiveness and success of that relationship. Trust ultimately means something like this: "If I entrust myself to you, you will respond with care and skill to help me. You will not hurt me directly yourself, and you will try to see to it that I do not hurt myself." For Natives to entrust themselves to an Anglo counselor or to a Native counselor they perceive to be representative of the dominant society may be extremely difficult given the historic evidence of the break in trust between the dominant and Native cultural groups.

The very skills that are used in establishing trust in interpersonal or counseling relationship--warmth, empathy, authenticity, honesty, and consistency--have been either misused, misrepresented, or completely lacking in past encounters between Native and Anglo, and the counselor will have to overcome the residual feelings of distrust the Native brings into the

relationship. The issue of trust takes on new dimensions. No longer is it necessarily based in the present.

NATIVE AMERICANS AND HISTORIC DISTRUST

Native Americans have been in this country for a very long time, and were here before the Europeans settled in America. When the Europeans arrived on the North American continent, they were met by a people who believed in trusting, giving, and sharing. These qualities exemplified the "Native Way". Unfortunately, the colonists did not reciprocate in kind, and the foundation for historic distrust was laid.

The "Indian Wars" were fought at great cost to people on both sides. However, it must be remembered that it was the Native whose land was invaded, and whose entire way of holistic living was interrupted and attacked. The Europeans who came to this country automatically assumed that anyone different from them was inferior and should be conquered and destroyed. The obviously negative feelings that Native people must have had toward the invaders did not cease, but were continually reinforced throughout history.

Native people trusted again when the Anglo offered treaties which then were not honored by the United States Government. They were forced to give up their own children, their traditions, their language, and their gods. Many also gave up their lives in the mass genocide that was carried out in the name of Christianity. Distrust of the dominant society and its members became a means of survival which negated the traditions of giving, sharing and respect.

More recently, reasons for continued distrust have become apparent. Citizenship was granted to Native people in 1924, but they continue to be treated as second class citizens in many ways. The government admits the need for Native education, yet threatens to eliminate federal Native education

monies provided for by the Indian Education Act of 1972. Indian people were "relocated" onto federal reservations (the least desirable, least livable land available) in the past, but because this reservation land has been found to be rich in minerals and other resources, the federal and state governments want the land back. In addition, there are Congressional bills calling for the termination of Indian tribes and the cessation of the rights of Indians as a sovereign people.

The above are only a few of the incidents that occurred in the past that have fostered feelings of historic distrust of the dominant society on the part of Native people. Since this distrust can be an interfering factor in the counseling relationship, it is important that the counselor try to understand it.

MANIFESTATIONS OF HISTORIC DISTRUST

The non-Native counselor needs to be aware that some of the behaviors exhibited by the Native client in a counseling relationship may have their foundations in historic distrust as well as in cultural differences. For example, the Native client may be silent and seemingly withdrawn. This behavior may stem from distrust, from a "wait-and-see" attitude. It may be based in the tradition of quiet that is prevalent in many tribes, or from a traditional respect for words. Words must speak the truth and be from the heart. How can one speak the truth and tell deep feelings to one's betrayor (the Anglo in general, not specifically the counselor)? Also inherent in this silence is distrust of the possible reactions of the counselor.

The Native client's distrust may be manifested through overt or covert hostility. This can be brought out into the open at the proper time.

Just as the non-Native may have some stereotyped expectations of Indians, Indians often expect certain types of behavior from Anglos, counselors included. Many of these expectations have their basis in historic distrust, and the counselor needs to be aware of their existence in order to better understand her or himself and the Native client, and the effect of their respective behaviors on the counseling relationship.

Giving advice: The Anglo may be viewed as always having a quick, ready answer for everything. Not only is this unacceptable in light of Native American's historic experiences with Anglo advice, but it also violates the Native tradition of non-interference.

Expecting change: The Anglo may be viewed as expecting (demanding) immediate change from the Native client (historically the Native has been forced to change to suit the demands of the Anglo, and this continues today). The client may not be willing to give up any more of his or her traditions, values, etc., and this must be respected by the counselor.

Judgmentalism: The Native client might expect the non-Native counselor to be judgmental. Many Native people feel they are "on trial" when they talk to Anglos. This can be attributed to the Anglo being the historic authority figure, and having power over Native people.

"White Liberal": Some Native people have a deep dislike and distrust of this type of person who has historically wanted to "help the poor Native," usually by imposing their values and beliefs on Natives.

Moving too fast: The Native client may expect the counselor to try to get to the "problem" too quickly, to try to get close too fast, and to expect them to make rapid decisions. Time is looked at differently in some Native

cultures and things are taken care of when the time is right according to an internal feeling or belief, not according to the clock. Expecting too much too fast may cause the client to try to figure out what it is the Anglo counselor doesn't want them to see, feel, experience, or question. This suspicion has an historical basis: Many policies, etc., were rushed past Native Americans without allowing them to be examined. Things take time in Native culture, but they last longer.

Inconsistency: Native Americans often view Anglos as emotional and erratic. To be inconsistent in the counseling relationship will only reinforce these beliefs. Also, for the Anglo (or non-Indian) counselor to "try to be Native" will destroy his or her predictability, and have a negative effect on the counseling relationship.

SUGGESTIONS

The Anglo counselor who works with Native American clients has some difficult obstacles to overcome around the issues of trust if the counseling relationship is to be productive. The counselor is not going to be able to "make up" for all the negative experiences Native Americans have had as a result of their interactions with Anglos, be they past or present. What the counselor can do, however, is try to understand and respect the feelings of the client, and proceed from there to provide the best opportunity possible for a good counseling relationship. The following are suggestions that may be helpful to Anglo and other non-Native counselors in trying to reach that goal.

(a) Be aware that the stereotype of the poised, self-contained, aloof Native may be the result of fear and mistrust of non-Natives.

(b) Self-disclosure is not consistent with Native tradition. The counselor will have to work hard to provide an atmosphere conducive to

emotional sharing. He or she must also be willing to learn to be an acute observer, rather than relying on verbal communication for cues.

(c) The counselor must be willing to utilize "non-conventional" counseling methods/approaches. Some counseling methods may not be suitable for the Native client.

(d) Give advice sparingly, and usually only if asked for. Advice is considered interference, and against the traditional beliefs of many Native people.

(e) Be real in the counseling relationship. The Native client will assume the non-Native knows little or nothing about Native people, and to appear to be "all-knowing" will harm the relationship. The non-Native who admits a lack of knowledge/experience with Native people will be more respected than the "actor".

(f) Recognize that there are very real differences between Native and non-Native people, and that whereas Native people have had to learn about the Anglo in order to survive in America, the Anglo has not reciprocated. If and when the Native client wants the counselor to know anything of a personal nature, he or she will present the information when they think the counselor is ready. It should be noted also that native people also have stereotypes of what Anglos and other non natives are like.

(g) In conjunction with the above, the counselor needs to be aware that questioning is not always acceptable in Native culture, and that misplaced inquiries may be met with silence, with a "non-answer," or if pressed, possibly with the Native client walking out of the session.

(h) The counselor should be aware that they will be watched very closely, and that inconsistencies and incongruence will reinforce negative feelings of distrust.

(i) Finally, counselor attitudes are more important than all the sophisticated techniques available.

Although not all of the above suggestions address historic distrust directly, they are all very much connected to it. The Native client is probably distrustful of the dominant society and Anglo people before entering into counseling, and if the counselor is insensitive and treats the individual as if they were a "minority group member" rather than Native, the counseling relationship may be doomed from the start. Sensitivity takes a great deal more effort, but is well worth the investment--both client and counselor will benefit.

Within the context of all of this background advising care, caution, and sensitivity to difference, there is a need to maintain your knowledge of general counseling principles with an appropriate degree of certainty and confidence. Counseling can work for many people in any culture if done correctly. For some, little or no benefit will result irregardless of culture. Despite cultural difference, much of what is known transcends culture and applies to most people. With training, supervision, and experience, the workings of these counseling principles become apparent, clarified, and refined.

It is most important to recognize that native culture is undergoing rapid change. This results in the necessity to counsel in a variety of cultural contexts. Each native culture, village, or individual is establishing in their own unique way the relationship between traditional native ways and the cash based technological social order. This results in a great variety of combinations which must be understood correctly for the general principles of counseling to be applied as accurately as possible.

DEPRESSION

Depression is a word that is heard frequently in everyday conversation. Under such conditions it can mean: "I just don't feel so good today", or "I am sad because my girlfriend said she didn't like me anymore," or "I am upset because my mother died last week," or "I have been feeling 'depressed' for months and don't know why."

All of us at different times have said, "I am depressed today" or, "I am down today." However, most of the time this feeling has changed and caused us no real problem. For the people who arrive for counseling, the depression is causing a problem.

Depression appears to follow something of a pattern and to contain specific elements. At the start of some depressive episodes there is stress. This can be the death of someone close, a divorce, retirement from work, or sons and daughters leaving home. More intangible things (which may be real or imagined) such as loss of respect or loss of status can also be the precursor to a depressive situation.

Frequently anger is associated with depression. It is very important to recognize the place that anger plays in depression because as we try to help a depressed person, this anger can be displaced or redirected from its original goal, to the person who is the helper--you. Because the anger directed toward us as helping people is misdirected, we have to be careful not to take it personally.

Frequently in response to stress, frustration, loss or disappointment, an individual responds not only with anger and depression but also with fear or guilt. These four emotions are each very painful and if not defined properly

and utilized correctly, they can become overpowering, overwhelming, frightening or even terrifying. It is possible to feel all four of these painful emotions at once, a very confusing experience to say the least. If these emotions become intense and are not used in identifying and solving problems, work performance may suffer. Similarly human relationships can deteriorate. Appetite may be reduced. Sleepless nights occur. Suicide ideas may occur followed by self destructive actions, homicidal behavior, or substance abuse.

Identifying depression as a problem for a person is not always a simple matter. It can be a mild, yet persistent, lack of energy accompanied by a solemn, gloomy mood. Or, it can be a profound state in which there is no verbal communication; suicide attempts; or deep hopelessness and despair.

I. SYMPTOMS

A. Physical - Change in sleeping, change in appetite, constipation, headaches, loss of energy and fatigue.

B. Cognitive -

1. Disturbed thought process, slowness of thought, trouble concentrating.

2. Depressive content, suicidal ideas, belief that one is bad, worthless, no good, etc. Belief that nothing will change, the future will be worse.

3. Unable to experience pleasure.

C. Feeling - Sad, helpless, hopeless, worthless, guilty, discouraged, blue, gloomy, describe the dominant mood in depression. It is important to discover whether or not these feelings are a reaction to some loss such as a death, losing a job, etc.

D. Behavior - Slow speech, decreased activities, frequent crying spells, periods of agitation (pacing, moaning, nail biting, hand wringing, etc.), suicide attempts. To what extent is the person's daily routine disrupted?

How are the important people in the person's life responding to these symptoms?

II. ASSESSMENT

The symptom picture just described is often broken down into two categories, based on whether or not the depression is a reaction to a recent loss. If the depression is a result of a death in the family, loss of a job, divorce, etc., it is necessary to assess how well the person is dealing with her/his feelings about the loss. When no immediate loss is involved and the depression is long standing, one should consider whether or not the person is in touch with reality, and whether the suicide risk is high (see Suicide sheet).

Although depression is an important reaction to loss, it is generally considered only one of several which people feel after a death, loss, or separation. The steps below have been described as the reactions people have when faced with their own death. However, they appear to apply widely to any situation involving loss or separation. Keep in mind, when evaluating any loss, that these steps may not always occur in the order shown and several may occur together.

A. SHOCK/DENIAL - Here the person says, "It can't be happening," or "It didn't happen," or "Oh, no." At this point the information is just too overwhelming for the person to believe. Also, in this stage the person may talk as if she/he accepts the loss, but act as if it did

not happen.

B. ANGER - In this stage the person vents their frustration and rage. If another person can be blamed (even if it isn't their fault) there may be cursing, shouting, physical aggression, etc. Sometimes, especially when there is a death, God is blamed and the person may talk about "injustices", "there is no God" or simply "hate everything." On the other hand, the anger may be held in, particularly if the person feels "it is not right" to express anger in times of loss or death.

C. BARGAINING - In this stage, the person tries to make a deal. They may pray not to die until after their daughter's wedding. Or make statements like, "If I do such and so, everything will be the way it was." Here, without accepting the loss, the person is trying to find a deal or way to make "everything alright," especially their own feelings.

D. DEPRESSION - Here the symptoms of depression are felt.

E. ACCEPTANCE - In this final stage the person is able to accept and deal with the loss. It is important to remember that acceptance does not mean liking it. Here the person recognizes their feelings, can cope with them, and can engage in appropriate behaviors.

In general, it is not helpful to tell a depressed person they should not feel as they do. Rather, attempt to understand their physical symptoms and feelings as completely as possible.

III. ALTERNATIVES

The alternative approaches to depression depend greatly on how severe the symptoms are. For plans dealing with suicide, see the suicide sheet. When the problem is less severe, the general steps outlined earlier can be followed.

POINTERS TO DEPRESSIVE ILLNESS

DEPRESSIVE ILLNESS:

-withdrawn, cannot relate to people

-misery and pessimism

-apathy and fatigue

-lack of interest in activities previously enjoyed

-sleeping badly, especially early waking

-may feel worse in the morning and improve later terrifying dreams

-difficulty in carrying out everyday tasks or making conversation

-withdrawal, sometimes because of fear of rejection

-slowing down of thought and movement

-social isolation

-feelings of worthlessness. "The world (or family) would be better off with out me."

-feelings of guilt and self-reproach, often without sufficient cause, delusions of incurable or bizarre illness

-loss of appetite and weight; constipation

-loss of sexual interest

-irritability

-indecisiveness

-preoccupation with illness, real or imaginary

-delusions of poverty

-wandering about the house or streets

-sense of futility

-loss of religious faith

SUICIDE RISK:

-fear of losing control, harming self or others

-preoccupation with or talk about suicide

-a definite plan for committing suicide

-previous suicide attempts

-family history of suicide

-painful or incurable illness

-drug or alcohol dependence

-tidying up affairs; giving away possessions

The risks are greater in the old and the ill. A trivial mental stress can set off suicide; even when people seem better, they will often carry with them strong suicide ideas.

OUR ATTITUDE TOWARD SUICIDE

The subject of suicide today is generally avoided in social situations. Although attitudes have improved, there is still a "hush-hush" approach that leads to the denial of the very fact of a suicide. Physicians and families alike may attribute suicides to other causes, particularly accidents. Christian churches and Orthodox Jewish law condemn suicide, and many people still regard it as a disgrace. In their funeral practices, some religious groups still punish both the surviving family and the suicide by depriving them, in varying degrees, of the usual burial rituals and rites that ordinarily help the family with its grief and bereavement. Society punishes the act in a variety of ways - sometimes, for example, payment of insurance is withheld.

All this would seem to reflect not only the general taboo that has surrounded death itself, but also the powerful taboos that are attached very specifically to suicide. Although the subject of death is now more openly discussed, the taboo still has a strong effect on society's attitudes and behavior toward suicide.

The taboo nature of suicide reinforces the reluctance of most physicians to even question patients about whether they contemplate suicide or have ever attempted it. The doctor is thus deprived of vital information, and the patient of the opportunity to ventilate feelings or obtain a referral for expert help. The taboo also keeps physicians from recording deaths as suicides and so contributes to the vast under-reporting of suicide and general unawareness of the extent of the problem.

Suicide continues to be invested with special taboos, which produce the feeling that it is evidence of weakness, a clear demonstration of being crazy, a sign of poor moral fiber and lack of courage, a declaration of sinfulness, inadequacy, and guilt, or an inability to endure physical or emotional pain. With such attitudes, it is obvious why people want to hide suicidal acts or thoughts of their own or of their loved ones. But the opportunity to seek or provide prompt and effective help is missed when the suicidal thoughts of attempts are not acknowledged.

SOME DEFINITIONS

Before discussing questions particularly related to suicidal adolescents, it would help to familiarize ourselves with some of the terms used by experts in suicidology (study of suicide).

Completed suicide: The circumstances surrounding the death lead to the conclusion that the individual took an action with the primary purpose of ending his/her life. This would include what is ordinarily meant when we speak of "suicide" or "committing suicide".

Suicide action: A person performs a life-threatening behavior with the intent of jeopardizing their life. This describes the behavior of a 12 year old who, following her parents' divorce, repeatedly overdosed herself with pills, tried to jump off a bridge, and tried stepping in front of cars. There is a full intention to die when such acts are performed.

Suicidal gesture: An act of self destruction that is not intended towards death but rather is geared as a message to others for getting help; an example would be cutting a wrist superficially in order to communicate to others the need for help. In this sense, a suicidal

gesture is either a conscious manipulation to get help or it can be a vengeful act against another to hurt them or gain power over them.

FACTS AND FABLES ON SUICIDE

FABLE: People who talk about suicide don't commit suicide.

FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

FABLE: Suicide always happens without warning.

FACT: Studies reveal that the suicidal person gives many clues and warnings regarding suicidal intentions.

FABLE: Suicidal people are fully intent on dying.

FACT: Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how they are feeling.

FABLE: Once a person is suicidal, they are suicidal forever.

FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.

FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.

FACT: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put suicidal thoughts and feelings into effect.

FABLE: Suicide strikes much more often among the rich or, conversely, it occurs almost exclusively among the poor.

FACT: Suicide is neither a rich person's disease nor a poor person's

curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, they are not necessarily psychotic.

SUICIDE

Suicide is one of the most difficult problems you will face in managing crisis.

One definition of suicide is: "Any act of self-injury which is apparently aimed at self-distraction, however vague or ambiguous, carried out or contemplated." The problem with using one word--suicide--to denote the entire range of self-destructive behavior and thoughts is that we sometimes assume that all people who are suicidal are in equal danger of killing themselves. Actually, each individual must be carefully evaluated for potential lethality (likelihood of completing a suicide). Later in this section you will find some guidelines for determing lethality.

REACTION TO CRISIS

While suicidal people come from all walks of life and have little in common as a group, they share the fact that they are in a crisis state. There may or may not be a precipitating event, but the person in crisis feels lost, hopeless, and helpless--unable to cope. Suicidal people tend to think in

extremes and usually find the crisis situation intolerable. There is both danger and opportunity in such a situation, for though the person may consider suicide as an escape from an overwhelming problem, the fact that the crisis situation cannot be tolerated indefinitely makes it a unique opportunity for intervention. Your task as a helper is to encourage some action toward change other than suicide.

Most suicidal people are ambivalent--they want to live and to die at the same time. Some people, seeing evidence of two conflicting feelings interpret the action as insincerity saying, "They really don't want to do it." Not understanding the very common suicidal characteristic of being of two minds at once can hinder a person's ability to help. The person's wish to die should be considered equally as serious as her/his will to live.

Suicide is often termed "a cry for help." Sometimes expressing suicidal thoughts or carrying out self-destructive actions are a person's only way to express the extremity of their distress. Some people in crisis drop tiny clues about suicidal ideas to people important to them; others more overtly tell their significant others that they are thinking of killing themselves. These clues, whether hidden or overt, can be thought of as a way of saying, "I'm in trouble...I hurt...pay attention to me." The response of the people who hear these cries for help is extremely important. If people respond to suicidal communications by ignoring them, disbelieving them, or denying them, the suicidal person may kill her/himself. If, on the other hand, someone listens to the cry for help and takes some positive action toward averting a suicidal act, chances are good that suicide can be prevented.

Talking with suicidal persons will cause you to face your own feelings about death. Since you are not immune to the powerful feelings about death created by our culture, you should try to become as aware as possible of your

own emotional response to the concept of death. If you are acutely aware of your own feelings before you take a suicide case, you will lessen your chances of having to deal with your own high level of anxiety at the same time you are trying to help someone. This does not imply that you will not have a high-level emotional response to a suicidal person but your awareness of your feelings before hand will insure that you will not be surprised by your emotional response, nor will you let your feelings get in the way of helping the individual.

You should not be afraid of using direct, up-front terms with a suicidal person. Sometimes the words, die, kill yourself, suicide, dead, corpse, etc. will help a suicidal individual face the fact that they are talking about death, a final, real, state. Also, the use of these terms will tell the individual that you are not afraid to face the reality and finality of death and that you are hearing clearly how they are feeling so lost, hopeless, and desperate, that death seems like the only way out.

HANDLING SUICIDAL PERSONS

No one can give you a recipe for handling suicidal persons because what helps one person may not work at all with another. There are some general guidelines which may work for you some of the time.

One of the most important qualities in you as a helper is your humanness. Coming across as a warm, caring person who wants to help is the first step in establishing a relationship and maintaining contact with the individual. You should communicate to the individual that he/she has done the right thing by coming for help and that you are willing to listen to everything the person wants to tell you about the situation and their feelings about what is

happening. As the story unfolds, you should listen carefully and give the individual feedback on what you're hearing. In the initial stage of the story it is important for you to indicate that you are hopeful, that problems can be sorted out and solved, and that you are willing to help the individual through this very difficult time. In no way should you deny the intensity of the persons feelings of helplessness and desperation.

PROTOCOL FOR LETHALITY ASSESSMENT

CLUES:

Suicide thoughts can occur where the presenting problem is not suicide. Clues can be verbal, behavioral, or situational.

Verbal Clues:	Direct	"I'm going to kill myself."
	Indirect	"I can't go on anymore."
		"Sometimes I drive so fast it scares me."
		"What's the use? Nothing helps."
		"You won't be seeing me around anymore."
		"Life has lost its meaning."
Behavioral Clues:		A previous suicide attempt. Giving away possessions. Inquiring how one donate their body to science. Poor adjustment to recent serious loss. Suicide notes. Sudden recovery from depression. Sudden behavioral change.
Situational Clues:		Loss of a significant other. Learning of terminal illness.

ASSESSMENT GUIDE

It is important to determine whether the situation is immediately life-threatening or is suicidal thoughts without imminent danger. If the individual puts out clues to suicidal thoughts, it is essential to check them out. Telephone crisis line guidelines are:

* REMAIN CALM - This will help the client to do so. Take your time. Establish rapport and win confidence as much as possible.
* Share your first name and indicate you want to help.
* If you get a name, check immediately in the active and alphabetical files for an existing case. If there is none, immediately check the closed files. This is important to gain information. Check the case plan or review notes and follow suggestions therein.
* Ask questions and gather information:

"Let's talk about what's going on with you."

"How would you like to talk about it?"

"I'd like to know more about what's troubling you."

* Ask directly if the client is thinking of killing himself or herself. Talk about suicide freely and openly.

"Are you thinking of taking your life (or killing yourself)?"

"Do you sometimes feel like it isn't worth living?"

"Have you thought about taking your own life?"

"You are sounding so resigned and depressed, are you thinking about killing yourself?"

Asking such straight-forward questions will not plant suicidal ideas in the client's mind. They are already there. What it may provide, however, is some much needed reality testing, and it may allow the individual permission

to talk about their feelings and thoughts, which their significant others may not be willing to hear.

* If the answer is "yes," you should always ask:

"How are you going to kill yourself?"

The answer to that question will help you to discover if the person has a plan and poses a serious threat.

To appraise the degree of risk inherent in a suicidal plan, remember the acronym L.A.S.

1. Is the proposed method a Lethal one?
2. Is the implement Available to carry out the threat?
3. How Specific are the details of the plan?

Ask about means, time, and all details of the plan. Refer to the SUICIDE POTENTIALITY ASSESSMENT sheet to help assess the danger.

Example: Have you thought about how you would go about killing yourself?" or "You say you'd use pills. What kind of pills?" or "You say you would use a gun. Do you have a gun? With you? Bullets in it? Do you know how to use it?" and finally "When might you use it?"

It is important to remember if the suicidal person is an alcoholic, has an impulsive personality, or is psychotic, the L.A.S. approach may not be applicable because the behavior of such people is so unpredictable. They will tell you one thing and then do something entirely different.

* If the means to commit suicide are present, ask the client to diminish the accessibility by putting away or locking up the pills, gun, razor, etc. For example, you might say something like:

"When we finish talking, will you put the gun away in another room?"

* Check out suicidal history. One-half of successful suicides have had a previous attempt.

"Have you ever tried to commit suicide before?" "Have you had these thoughts before?" "How long have you felt this way?" "What happened before?" "When was this?" "What did you do to overcome the feelings before?"

* Has anyone else in his/her family made a suicide attempt or committed suicide? What happened?

OTHER INTERVENTIONS

"You said counseling helped you following your last suicide attempt. Are you willing to go back into counseling now, before you get to that desperate state again?"

Ask the client if they have had a physical examination recently to rule out a physiological basis for their feelings. If not, ask if they are willing to see a doctor.

* Ask the client who the significant others are in his or her life, and then ask if they are available emotionally and/or physically. Suggest getting in contact with them.

Most suicides involve feelings about oneself in relation to a significant other. Encouraging the person to talk about this can allow dealing with feelings in a way other than suicide.

Ask who would be effected by the death? "Is it revenge?"

* In discussing the person's problems, help them to partialize or separate problems in order to deal with one problem at a time. Suicidal feelings can result from being overwhelmed with a series of problems, to the point that the person is unable to separate and deal with each problem one at a time.

* Emphasize the individual's assets, abilities, and successes. A suicidal person is usually quite depressed and is not able to see their assets and

strengths. Everything looks negative. Provide feedback about what you see as positive, but don't argue.

* Emphasize the temporary nature of the problems that help is available to reduce the problems. But, that death is permanent.

"I understand how you feel right now, but you can get help." "Help is available." "Suicide is the last resort, there is hope." "Suicide is the end, it is the last thing you will ever get to try, so what have you to lose by trying an alternative first." (Such as counseling, talking things over with their partner, etc.)

* Explore other courses of action. Suggest other ways to resolve the problem. If the person resists, BACK OFF!! Don't push them to abandon their suicide plan.

"What has been keeping you alive so far?" and "What other ways have you tried to deal with this situation?"

* Ask the caller if she/he would be willing to talk to you when feeling suicidal in the future.

"Would you be willing to call us before you try to kill yourself?" or "I'd like for you to agree to return if you feel like killing yourself again, would you agree to that?"

* Ask the individual what the chances are that he or she will kill themselves.

* Arrange a follow-up with the client's permission. A follow-up is necessary to assess how the client is feeling, to determine whether or not a referral was acted on, and to give the client encouragement and support. If the client agrees to let you do a follow-up call to them, it provides you with a telephone number, which may be critical information if the client calls again as a suicide in progress.

* Open a case, if there is not an existing file, write descriptive entries quoting the client's words and phrases and outlining the resolution or plan of action agreed upon.

THINGS YOU SHOULD NOT DO:

-Don't play down the client's feelings or plan. Always take suicide thoughts and plans seriously.

-Don't leave the client alone if suicide is imminent.

-Don't tell them they're being selfish or a coward, etc.

-Don't promise unrealistic things.

-Don't stress the shock and embarrassment that the suicide would be to the person's family

-Don't sound shocked by anything the person tells you.

-Don't engage in a philosophical argument on the moral aspects of suicide because you may lose both the argument and the suicidal person. Be willing to accept failure. Some people are determined and there is nothing we can do. No matter how skilled you are, you may eventually talk with someone for whom none of the above will work. Be aware of that and don't take the failure personally.

DETERMINE IF THE CLIENT IS CHRONIC OR ACUTE

Be aware that chronics are a very high suicide risk group. Indicators for chronics are not the same as for those of acute clients.

INDICATORS OF CHRONICITY:

-long duration of problem

-history of psychotropic medications

-history of psychiatric hospitalization

The following indicators are associated with suicidal behavior in the chronic population:

-prior lethal behavior

-depression

-not willing to accept help

-loss of a usual resource

SPECIAL RISK GROUPS:

*elderly *chronic alcoholics *schizophrenics

*males *drug abusers

ACUTE CLIENTS:

The following emotional symptoms are associated with suicidal behavior in the acute population:

-hopelessness -ambivalence

-helplessness -psychological exhaustion

-depression -having no alternatives

The most important behavioral clue to suicide is a sudden change in a behavioral pattern. Suicidal persons often exhibit:

-suicidal ideation -social withdrawal -mood swings

-loss of appetite -preparations for death -sleep disorders

-poor impulse control -increased use of alcohol or drugs

Many suicidal people also have had:

-a recent visit to a doctor -recent hospitalization

None of these indicators, however, are full proof that a suicide will occur. They simply indicate an increased risk.

Often suicide victims are in a situational crisis indicated by:

-loss of a loved one (death, separation, divorce), self-esteem, job, good health, etc. Especially multiple losses.

-financial troubles

-little or no support system

RISK GROUPS:

*elderly white males
*alcohol abusers
*acute psychotics
*adolescents
*veterans
*M.D.'s dentists, & pharmacists
*chronic illness patients
*homosexuals
*American Indians

ASSESS THESE SUICIDE INDICATORS

Lethality of means, Availability of means, Specificity of plan.

Suicide Potential Evaluation

The higher the number of "yes" answers to these questions, the greater the suicidal potential.

1. Is this person male?
2. Is the individual an older white or younger minority?
3. Is the individual separated, divorced or widowed?
4. Is the individual retired or unemployed?
5. Is the individual presently living alone?

6. Is the individual unconscious (second party calls: someone calling in behalf of someone else) or unable to answer coherently as a result of the present suicide attempt? Has the individual been at their present address less than 6 months? Transient?
7. Has the individual attempted suicide before?
   a. now in the process of attempting?
8. Has the individual had a previous psychiatric hospitalization?
9. Has the individual been in poor health in the last 6 months?
10. Has the individual written a suicide note or will?
11. Does the individual now have, or have they ever had, a problem with alcohol?
12. Drug addiction?
13. Homosexuality?
14. The law?
15. Has the individual suffered a loss--real, threatened or fantasied, within the last 6 months, such as death, separation, financial, self-esteem etc.
16. Does the individual threaten suicide or have plans of suicide? (concretely or by inuendo)

PROTOCOL FOR HANDLING A SUICIDAL INDIVIDUAL BY TELEPHONE

SUICIDE IN PROGRESS

AND TRACE

If you have a developed a relationship with a client, he/she may call you while in suicidal crisis. Similarly, others previously unknown to you might

know you are available for such emergencies. Should you receive a suicidal call, the following protocol should be of use.

A suicide in progress is occurring when a person has already taken action that is likely to result in death if intervention is not provided soon. (Between several minutes to two hours.)

Be familiar with the "Suicide Ideation Protocol" and use suggestions therein to help you deal with the Suicide In Progress.

REMEMBER - Most suicidal people are ambivalent about committing suicide and frequently will give us necessary information when we request it, or will indirectly reveal just enough to allow us to intervene.

* REMAIN CALM - Your anxiety will only interfere with your efforts to help. You have time (15 minutes to 2 hours) to help, usually.

* Identify yourself by first name to the caller, and ask them to share their first name with you.

Attempt to find out the caller's name, address, and phone number where they are calling from, and who, if anyone, is with them. It is important to ask where the caller is at the time they are talking to you. They may not be home, so it is important to phrase the question as follows:

"Where are you right now? From where are you calling?" Immediately check the active alphabetical files for an existing case, if they give their name. If there is no such name in the active files, immediately check the closed files.

Checking the files is essential. If an existing case on the caller is found, it may provide critical information on the appropriate procedures to follow, and it may provide the identifying information you need to provide linkage with the emergency services network. If the file does not reflect

specific guidelines, sufficient identifying information on the caller, or there is no known file in existence, follow the procedures outlined below.

* Get as much specific information from the caller as possible.
  Utilize the techniques outlined in the suicide ideation protocol.
* Determine what action the person has taken to commit suicide.
  Example;

PILLS: What kind? How many milligrams? How many taken? When? What other drugs were ingested? Has the caller had any alcohol? How much does the caller weigh? What symptoms is the caller having?

In overdose cases, your partner will call Poison Control regarding the severity of the caller's situation.

POISON: What kind? (brand name) How much? When was it taken? How was it taken? (injested or injected) Has the caller vomited? What symptoms is the caller having?

As with overdoses, your partner will consult with Poison Control regarding the severity of the caller's situation.

SLASH WOUNDS: What area is injured? What was used to inflict the wounds? Has the bleeding been controlled?

GUNSHOT WOUNDS: What kind of gun? Rifle, handgun, shot gun? Where was the wound inflicted? What sort of gun was used? Has bleeding been controlled?

TRACE only if the caller is unwilling or unable to give the needed information. Tracing is not a substitute for building trust and good phone skills. It should be used only when danger of death is imminent.

Your partner, if you have one, will request the trace.

TRACE PROCEDURE:

Dial 911, identify yourself by name and affiliation with the Suicide Prevention and Crisis Center. Tell the person who answers, that you have an emergency call, explain in detail, and request a trace. They might ask you to stay on the line until the trace is completed or they tell you it's impossible to trace.

When a trace is in progress, attempt to keep the caller on the line by whatever means possible. Ask the caller to tell you the story of their life, or tell them the story of yours...ANYTHING. If the caller passes out or leaves the phone, DO NOT HANG UP until you hear a dial tone. AS LONG AS YOU DO NOT HANG UP, THE CONNECTION IS STILL MAINTAINED AND THE TRACE CAN STILL BE MADE.

Pay attention to background noises...planes, highway, tavern, etc., and ask the caller about them. A good ear for these sounds maybe valuable in determining the caller's location if the trace is not completed. Other valuable indicators are geographical clues such as: schools, parks, shopping centers, churches, airports, etc. The caller may "drop" such clues or you may be able to get them by your line of inquiry.

WHEN TRACE IS COMPLETED: Someone from the police department will call back, or if the line is still open talk to you on the same line the caller was using. Explain the situation to the police, be sure to let them know if the caller has a weapon.

If trace is unsuccessful, but you have an address, call the police dispatcher, explain the circumstances and request the police send a patrol car over to investigate. This procedure is also effective if you only have a telephone number. The police have means to obtain the address from the phone number.

If you have a general location, such as a phone booth near a specific intersection, parking lot, or bar, it may be possible to locate the suicidal person. Call the police dispatcher, explain the circumstances, and request a police unit patrol that area.

* If intervention is not successful because the caller disconnects before identifying information is received or before the trace can be completed, YOU HAVE DONE ALL THAT CAN BE DONE.
* Follow-up procedures: If intervention is successful, get as much information from "911" as possible regarding disposition: Was the caller transported? To where? The second step in the follow-up procedure is to call the hospital: Was the caller admitted? If not, was the caller referred elsewhere? If so, what is the caller's condition? Will the caller be contacted by a counselor while hospitalized? Write up your report giving all the details including descriptive entries quoting the caller's words and phrases and outlining the intervention affected.

The follow-up information must also be noted in the case. If you must leave before follow-up, request a form and attach it to the report. Be sure to include in your case notes exactly what you want done in the follow-up, when it should be done, what questions should be asked, and where to call.

SUICIDE

TEEN-AGE SUICIDE

Why does a child come to feel such loneliness and pain that life no longer seems worth living? There are no sure answers, but there are warning signals that may help prevent this kind of tragedy.

Linda's voice is soft, her face gentle. Of two teenage sisters one year apart in age, Linda was always the shy one, things seemed harder for her. Her sister, Peggy, was outgoing and cheerful, with boy-friends and medals in figure skating. But when Peggy was 16, something began to change. "She'd always gotten A's and B's, but now she thought she was stupid," Linda says. "She thought she didn't have any friends, but she had gobs of them. She said she was fat--but she was skinny as anything. I don't know what she expected--nothing she did was good enough." All of her life Linda will remember the sunny winter morning when Peggy came out of her bedroom and put her arms around her father. "I love you very much, Dad," she said, "Everything's going to be fine." She walked back into the bedroom and shot herself through the head. In an instant her life was over.

We are stunned by these stories. And frightened. And angry. We have worked so hard to make our children happy--and yet for some of them life seems to be not worth living. Every year, about 2,000 young people in this country between the ages of 10 and 19 actually kill themselves--twice the number known even ten years ago, and experts fear that many more suicides are among the growing number of "accidents" on highways and in homes. At a time when most Americans live longer than ever, and killers such as smallpox and diphtheria

no longer claim our young, we must face a new threat to life. For every teenager who succeeds in killing him or herself, perhaps 50 others make serious suicide attempts that fail. It's no exaggeration to say that the issue has reached serious proportions. Many teenagers are having enough trouble coping that they see suicide as the only way out of their problems. Those who commit suicide are not primarily poor, sick or destitute. In the last twenty years adolescents who have every advantage are becoming the high-risk suicide group.

It is hard for Americans to give up the idea that adolescence is a simple minded stage. Caught up in their own problems, it is difficult for adults to look back with understanding at a time that they remember as carefree. "We've given our kids everything," one father said angrily, sadly. "What do kids today want?" When parents and teachers feel like this, a troubled teenager is plunged into even further isolation. Adults forget what a tough time it can be. As people who are neither adults nor children, adolescents often feel cut adrift. No longer able to cling to their parents as they once did, their peer group often takes on the importance of a life jacket bouying them up. But this life saving peer group itself is composed of members who are all relatively insecure.

Researchers agree that probably never before in history have young people been exposed to such a variety of tensions and social changes. And perhaps never before have they been so ill equipped to meet them. Over the last twenty years there has been a steady decline in the ages of people becoming involved with drugs, alcohol, and sexual activity. These pressures have combined with insufficient and inadequate family support. More than ever

today, our children first need roots to anchor them; then wings to carry them into their own lives. But that's not what some kids are getting.

About 300,000 adolescent girls made unsuccessful attempts at suicide last year--three times as many girls as boys. But for the first time girls, who in the past had used such passive and perhaps more half-hearted methods of self-destruction as sleeping pills, are now taking the "masculine" ways out and hanging and shooting themselves.

"Our daughters are being asked to find out who they are in a culture that is in itself having a severe identity crisis," one researcher says. "Caught between the traditional world of mother and the new frontier of freedom, they're propelled toward fulfilling all possibilities the changing world offers. It's an impossible goal that is taking its toll." As one teenage girl put it, "It used to be okay for girls to sit back and let things happen. But now you think you have to be pretty and smart and get into a good college and be a lawyer or something. It gets to be an awful lot to keep up with."

And as the pressures of life build, so does the urgency for quick solutions. "Teenagers watch television and see that life problems are presented and fixed in a half-hour program," say Dr. Mary Giffin. "It gives people an automatic sense that things should resolve quickly. But what happens in real life is that many problems don't resolve. You have to learn to live with them, to adapt and cope."

Overwhelmed, many young people withdraw. Especially if they live in families where anger and grief are not seen as normal human responses that can be faced and dealt with constructively. Teenagers may withdraw into a shell of silence-and suppress their feelings in shame until they build to an unbearable sense of worthlessness and rage. Others may turn these feelings outward against the world that has been "unfair" to them. Young people often

associate themselves with the more impulsive, angry, explosive characters they see on TV. When they get frustrated, they let everybody know. If you're unhappy, they feel, you should physically alter your environment, make a lot of noise about it. If one makes enough fuss and shouts enough and gets angry enough, or goes smashing around in cars, then other people will give them what they want. The frustration mounts, they take pills or alcohol or drugs.

Money buys lots of things. It buys instant gratification. It buys all kinds of seeming opportunities to make oneself feel fulfilled. But what is missing in some families is the ability to develop coping skills, to teach calmness, to teach perseverance. Everybody's going to experience disappointments throughout life in how they see themselves and goals that they fail to achieve.

Without coping skills, many will turn to the quick cures of drinking, drugs and violence; as opposed to persevering through difficult times and doing the hard work one needs to do in order to sustain rich goals and relationships.

Alan is a 17-year old, lanky and soft-spoken. When he was 15, he went behind the school stadium and cut his wrists. He remembers passing out--"from being scared as much as anything." A coach found him and called an ambulance. "Everything seemed to be sort of wrong," he says. "My girl friend broke up with me and I was having trouble in Trig and some of my other classes, and it started to scare me. Yeah, I guess I tried to talk to my folks, but they seemed to have stuff of their own on their minds, and I thought I shouldn't bother them. I guess I sort of panicked. I said to some of the guys 'maybe I should just kill myself,' but I guess they thought I was joking. That night after a real bad practice, I went behind the bleachers and cut myself with my hunting knife, hard." Even in his distress, Alan now has an awareness of something tugging him in the opposite direction. "I remember thinking about

climbing the water tower and jumping, but I guess I knew that would really kill me. This way I guess I knew somebody would come along and find me."

There is the story of a young man who jumped from a tall building. His fall was broken by an awning. People who saw him jump rushed to his side and heard the boy pleading, "Don't let me die, don't let me die." The rescuers were stunned. If the boy didn't want to die, why did he jump?

A very deadly act always reflects an ambivalence, one expert says. A person who makes a suicide attempt is usually very determined to die, but once they feel the poison in their body or have that moment of realization about what they've done, the other side of their ambivalence becomes real and they don't want to do it. Some people see that ambivalence and say, "Oh, they weren't really serious," because they called their mother or called their therapist or turned on the gas just before they knew someone was coming. They are serious. About both feelings.

A book by Fran Arrick, about teenage suicide is called Tunnel Vision. "Tunnel vision is the inability to see anything else in life but the loneliness and pain of that particular moment," she says, "It's the inability to step back and know that things will get better. Grown-ups know that you get over certain disappointments and setbacks, that they won't affect the rest of your life. But kids think, I wasn't invited to a party, or, I'm breaking up with my boyfriend, and they can't see beyond that." As one teenager put it, "It sounds crazy, but I think it's true--kids end up committing suicide to get out of their finals." But although that final push may indeed come from something so small, the buildup to it has been gradual.

The teenager who has reached the point of seriously considering suicide usually gives warning signals. In the majority of cases, there will be obvious signs of deep depression. Slowly a young person will withdraw into

helplessness and apathy. Grades drop; hobbies, sports, and other activities that were once important are now ignored. Sleeping and eating habits may change; there may be sudden outbursts of fury or unusual and reckless behavior. The teenager communicates less and less and becomes more and more isolated. And then may come the signs that some psychiatrists call the "last minute cries for help." Teenagers may give away treasured personal possessions. They become preoccupied with the notion of death in music, art, in the poetry or journals they write. And they will say it out loud--that they are worthless, that their families would be better off without them, that they want to die.

If such a youngster can be identified, a number of suicides can be prevented. Doctors, teachers, friends and families need to know what to look for. Many teens go to their doctors before they commit suicide because they are not feeling well. And the doctor checks them out and says they're physically fine--but fails to ask the right questions: How are you getting along? Are you down in the dumps about something? Most kids are going to respond if questioned in this way. If teachers, friends, and family members know what to look out for and let the person know they care enough to talk to them about it, a lot of kids are going to feel that somebody cares enough to keep them going.

"I tell young people to remember that suicide is a permanent answer to a temporary problem," says a psychotherapist whose own college aged son committed suicide. "I tell parents to remember they are not powerless when they sense their child is having trouble. There are things they can do, ranging from simply showing their concern and offering to help in any way possible to going for professional help themselves, to actually forcing a child to go for help or hospitalization if necessary. And then whatever

happens, because parents also have to remember that what a child does is ultimately his or her responsibility and, for reasons you will never understand, some people are going to take their own lives no matter what--you will know that you have done everything you could."

Again and again, worried parents, towns and school systems reach out for help. Anxious parents ask, "What signs do I look for? How do I know this tendency isn't hidden in my child?" The chief message some professionals try to get across is that if they have any question about their own child they should verbalize their fears sooner rather than later. Most people hesitate to speak up about something they're not sure is present--they somehow seem afraid they'll put the idea into a child's head. But, if you sense it, verbalize it. If you think your child might be suicidal, say, "You seem awfully down, let's talk about it." Open up the subject. If you put a fear into words, it serves to defuse it. It transforms the fear into something tangible that can be dealt with. It's deadly not to talk about it.

Other families fear that any pressure at all will be harmful to a sensitive son or daughter. One family reflected on their 17-year old son's suicide. "He said he wanted to go to medical school," the mother said. "So we really kept after him to get A's--we kept telling him C's weren't good enough. But we felt if we didn't put the pressure on him we'd have a kid who would be parking cars for the rest of his life. It's hard to know where to draw the line."

But experts agree it is not always the pressure itself that is harmful. While some young people may thrive on it, the problem is more pointedly the strain of meeting impossible goals in an increasingly competitive society. A child needs to be assured, psychologists say, that no matter what happens the child will be loved unconditionally for who he or she is rather than what he

or she has accomplished. As the father of one young suicide said, "If I had to do it all over again, I would spend more time hugging him than nagging him."

A young woman named Barbara recalls that when she was in high school and college, several of her classmates and friends killed themselves. So many students took their lives at the university she attended that it prompted a local television documentary: "College Can Be Killing." One boy hanged himself in his dormitory room; another girl went into the garage of her family home, turned on the car motor and asphyxiated herself.

"When one of my friends who was a little younger committed suicide, my first reaction was 'Why didn't you wait another year?' I saw so many kids going through what I went through--for a while I'd been so depressed I thought about killing myself, too--and I wish they could have known things would be better if they just waited it out. Fourteen! You haven't begun to know the most meaningful things in the world yet!"

"I'd tell parents to encourage their kids to take small steps, they don't have to be big ones. Sure, you should encourage kids to do their best, to use their best abilities. But you've got to make it clear that, no matter what, you love them anyway. When I went to school, everyone was so crazed that they had to be the top, the best, the head of everything. It's so ridiculous. I think some kids think they're failures just by being themselves."

"I would say to parents, 'Pay attention, listen to what your child is saying.' If you're active and involved in your kids' life, then you'll know if something's not right."

Some recent surveys of teenagers throughout the country say that the majority of young people have a generally positive outlook on life and feel they can talk to their parents and count on their support and advice. What

remains a mystery is why some boys and girls survive and others crumple. One father reflected on his 17 year old son's suicide. Why, in a family of four was this child unable to cope? "If when he was a baby in the hospital he had been marked 'fragile, handle with care,' maybe you would know," the heart-broken father said. "But you don't know sometimes--until it's too late."

Experts can offer no sure answers. "One of the things that often motivates suicide is a young person's having very high hopes, very romantic wishes for high degrees of personal gratification," says one doctor. "They'll often have a high sense of personal importance, either reflected in the eyes of someone they're romantically attached to or in a literary romantic sense that they're going to do wonderful and important things. And when that doesn't happen, that leaves them a long way to fall. But why that fall leads some young people to self-destruction is just impossible to say."

And with the climate of our society as it is today, one resident of the American Association of Suicidology, thinks that the teenage suicide rate can only continue to rise. "This kind of violent behavior," he says, "is closely related to other increasingly violent and unstable aspects of our society, the increased use of alcohol, the ready access to handguns, the direct exposure to violent behavior and 'romantic' notions of death as seen as television and in the movies. And, since much teenage depression results from personal loss, the rising divorce rate is a factor, too."

Many counselors feel that coping skills should be taught as part of the school curriculum beginning in kindergarten. One psychologist says, "There are four things we've got to teach our kids in order to survive," she says. "We've got to develop an individual's self-esteem so that each person has an internalized, intrinsic value because of who he or she is not because of what

he or she does. We've got to teach communication skills so that each person can learn to express and discuss their feelings. And we've got to teach what I call 'positive failure.' In a culture that promotes being 'number one' in all that we do, it's important for kids to know that the effort is positive, that they can enjoy and grow from what they do regardless of the outcome. And finally we've got to help individuals learn how to handle grief. Many suicides are triggered by some sort of a loss--a parent, a good grade, even a prom date--we've got to help people learn how to deal with losses and even grow from them."

One hospital holds seminars for students that dispel any romantic notions they may have about suicide. "I want kids to know it's not this dreamy scene where they're laid out looking like Snow White while everybody sobs and says how wonderful they were," a psychiatrist says. He shows slides of real corpses in real emergency rooms, and describes in graphic detail the procedures for dealing with the broken and distorted bodies. He talks about the agony--and the anger--that can ruin the lives of family and friends. "It really sobers up a lot of kids. They see that the act of suicide is ugly and mean--and there's a lot of heartache and grief involved.

Other schools and communities do what they can. Several hundred school systems have created peer counseling programs where youngsters can talk to teachers and to one another about what is troubling them. One school system in Colorado actually has a required course in suicide prevention ceveloped by a school psychologist when he talked to an eighth grade class shortly after a ninth grader had committed suicide. "The kids were devastated," he says. "It convinced me of the necessity of some sort of student program to deal with this. No, the schools should not act as a menta' health center for long term therapy. But crisis for most kids doesn't happen in a psychiatrist's office

or hospital; it happens in the school and in the community, and we're all morally obligated to help. We need to intervene now, while these kids are still open to talking about and learning from all this."

"Everything we know about suicide tells us that people who try to take their own lives really want desperately to find a better way," says one therapist. "If there's a positive aspect to this, it's that the potential for prevention is very high. If the cry for help is not ignored, it can have a positive effect for bringing about change, for helping people turn desperate situations around and tapping their own strengths."

"If you want to stop the suicide epidemic, we must break the conspiracy of silence that surrounds it," says Francine Klagsbrun, author of Too Young to Die: Youth and Suicide. "Cancer used to be something people kept as secret as possible, but because of campaigns to recognize symptoms and get early treatment that saved their lives. In the same way early symptoms that may lead to young suicides can be publicized and taught. And if just one extra life can be saved because a friend has learned to help, that will be a beginning.

EVALUATION AND EMERGENCY MANAGEMENT OF SUICIDAL PERSONS

Suicide is one of the most difficult problems confronting persons in the helping professionals. This applies not only to the professional therapist but to all occupations concerned with the health and well-being of the public. It is rare that any psychiatrist, psychologist, social worker, nurse, physician, minister, police officer or educator can conduct their affairs without at some time being faced with the need to evaluate and handle a suicidal situation.

SUICIDE AS A TERM

Confusion often accompanies the use of the term "suicide." One result of this confusion is the indiscriminate application of the term "suicidal" to patients with the implication that all such persons are in equal lethal danger. Experience has shown that suicidal persons vary in lethal potentiality from minimal to highly serious, and that each person requires individual, careful evaluation. Suicide is an ambiguous concept leading to confusions of behavior, end-result, and intention. When a person is called suicidal, these aspects must be clarified.

CHARACTERISTICS OF THE SUICIDAL SITUATION

Crisis: The suicidal person is usually in the midst of a crisis. Crisis has been defined as a turning point in the course of a situation, whose outcome decides whether possible bad consequences will follow. It includes a problem which cannot be solved quickly by the individual's normal range of problem solving mechanisms. For the person in a suicidal crisis, the principal factors are the overwhelming importance of an intolerable problem and feelings of hopelessness and helplessness. The pressure of these feelings compel the person toward action for immediate resolution. The action may be maladaptive, as in suicidal attempts.

Crisis provides an unusual opportunity for therapeutic intervention. Crisis, by definition, implies a state that cannot be tolerated indefinitely. Something must change. The initiation and timing of therapeutic efforts during the crisis can influence the situation toward a favorable outcome.

Ambivalence: One of the features characterizing the suicidal person is ambivalence, expressed through feelings of wanting to die and wanting to live, both occurring at the same time. An example of ambivalence is found in the

person who is angry at a loved one over a real or imaginary hurt and is filled with strong feelings of both love and hate for the other. Such a person may ingest a lethal dose of barbiturates and then call someone for rescue before losing consciousness. The relationship and strength of the two opposing impulses to live and to die will vary for different conditions. Most people have a stronger wish to live than die. It is this fact of ambivalence which makes suicide prevention possible. In working with a suicidal person it is necessary to evaluate both motives and their relationship to each other and to ally oneself on the side of the fluctuating wish to live.

Communication: Suicidal activity is frequently a desperate method of expressing feelings of hopelessness and helplessness. Suicidal people are reduced to this method when they feel unable to cope with a problem and feel that others are not perceiving or responding to their need for help. The suicidal behavior thus becomes a claim for the attention which they feel they have lost. The communication may be in terms of verbal statements such as "I no longer want to live" or "I am going to kill myself" or it may be in the terms of actions such as the procurring of pills or guns, a sudden decision to prepare a will, or the giving away of treasured possessions. The communication may also be either direct or indirect, and is frequently aimed at a specific person. When it is indirect, the problem is to recognize the intent of the disguised message and to understand the real content of the communication. Recognition of the communication aspects of suicidal behavior facilitates a more accurate evaluation of the various factors in the situation and allows for more appropriate and helpful responses.

The Worker in Suicide Prevention

The effect of the suicidal communication: The suicidal behavior can further be understood in terms of the effect upon the recipients of communication. For example, the communications may arouse feelings of sympathy, anxiety, anger, hostility, etc., in family or friends. Similar feelings may be aroused within the worker unless she or he can anticipate and counteract such reactions. A universal tendency of which the worker must be aware is the desire to be omnipotent. Then (but only then) it would be possible to solve all the problems and meet all of the demands of every patient. Intensely dependent patients attribute tremendous powers to the potential rescuer.

Many suicidal situations will arouse within the worker feelings of anxiety and self-doubts of their adequacy to handle the critical situations. While a moderate level of anxiety is appropriate, too much anxiety may seriously hamper the worker, especially if it is transmitted to the patients who, at this point, are depending upon the worker to help them solve their problems. The suicidal person who feels helpless and lost, perceiving excess anxiety in the worker, can lose hope in the possibility of being helped. As in other aspects of life, suicide prevention workers develop confidence and poise with training and experience.

Feelings about death: Death is a part of life and living, but in some cultures it has always been surrounded by powerful taboos. These taboos and the feelings they arouse may effect the workers and even interfere in the interaction with the patient, unless workers are sensitive to their own feelings about death. Whatever their own feelings, workers must avoid any tendencies toward moralistic attitudes toward death and suicide. The worker's point of view, within professional situations, must be that death is to be

prevented, if possible; but the existence and merits of other viewpoints must be recognized, too.

BASIC PRINCIPLES OF SUICIDE PREVENTION

The following comments are offered as guidelines for effective and comfortable functioning in working with suicidal persons. It is, of course, impossible to anticipate every situation.

In most cases, suicidal crisis will go through stages. The person first comes to the attention of the family, relatives and friends. In the second stage, they may come in contact with front line resources, such as family physician, clergy, police officers, lawyers, school personnel, and public health nurses. If the suicidal tendencies persist, the next line of resources is called into play, the professional person and agency. The final resource may be the hospital. The professions involved will be mental hospitals, general hospitals, psychiatric clinics, social worker agencies and various service agencies such as family service, community health aides, community health representative, vocational rehabilitation, and employment offices.

Recently, suicide prevention services have been started in various cities throughout the country. They are characterized by two essential components, no-waiting service and twenty-four hour availability. They offer varying degrees of service, but all of them depend on communication by telephone.

The handling of a telephone call from suicidal persons generally involves five steps. These steps may or may not occur consecutively.

A. Establishing a relationship, maintaining contact, and obtaining information.

B. Identification and clarification of the focal problem(s).

C. Evaluation of the suicide potential.

D. Assessment of the patient's strength and resources.

E. Formulation of a therapy plan and mobilization of patient's and other's resources.

Each of the steps is discussed in detail below:

A. Establishing a relationship, maintaining contact, and obtaining information:

In general, the worker should be patient, interested, self-assured, hopeful and knowledgeable. He or she will want to communicate by their attitude that the person has done the right thing in calling and that the worker is able and willing to help. By the fact of the call, the patient has indicated a desire for help with the problem. The patient should be accepted without challenge or criticism and allowed to tell the story in their own way, with the worker listening carefully to the information volunteered. The response, both in terms of attitude and tone on the telephone will make a significant impact.

Sometimes, because the patient will not have a clear idea of the agency's functions, it will be necessary to make clear the services offered. For example, the patient may request financial aid or a home visit, and, if these are not part of the services, this must be clearly stated.

The telephone response should be initiated with a clear identification of the worker, and a request for the name and telephone number of the caller. Names and phone numbers of interested other persons such as family, physicians, close friends, or others who might be possible resources in the situation should also be obtained. The worker's immediate goal is to obtain information to be used in an evaluation of the suicidal potentiality. This is usually best accomplished by asking direct, specific questions about the

caller's suicidal feelings and plans. For example, "How do you plan to commit suicide?" "Do you have pills or a gun?" "When?" etc. It is the patient's reason for calling, and to talk about it without undue anxiety is helpful in reducing the patient's own anxiety about their suicidal impulses.

B. Identification and clarification of focal problem(s):

The suicidal patient often displays a profound sense of confusion, chaos, and disorganization. They are often unclear about the main problem and have become lost in details. One of the most important services of the worker is to help the patient recognize and order the central and secondary problems. For example, a woman caller presented a profusion of symptoms with feelings of worthlessness, despair, and inadequacy, saying she may not be a good mother, she couldn't manage her housework, and her family would be better off without her. All this was accompanied by incessant weeping. Questioning revealed that her main problem lay in her relationship with her husband. A statement to this effect provided her with an authoritative definition of her central conflict and she was now able to address herself to this identified problem more effectively. In some instances the caller may be clear about the central problem, but indicate that they have exhausted all their own alternatives for a solution. The worker, as an objective outsider, might be able to provide a number of additional alternatives for the patient to consider.

C. Evaluation of suicide potential:

Suicide potential refers to the degree of probability that the patient may kill her or himself in the immediate or relatively near future. A number of criteria to evaluate suicide potentiality have been developed out of research and experience at the Los Angeles Suicide Prevention Center. Suicidal potentiality will vary in terms of lethality from minimum to maximum -- in which the possibility of death occurring is great and immediate.

As soon as the worker begins to talk with a suicidal caller, the worker has assumed some responsibility for preventing the suicide. To do so the worker must have an accurate evaluation of the lethal risk within the suicidal behavior. The plan of action formulated by the worker will depend upon the evaluation of the suicidal risk, plus an appraisal of the patient's focal problem, their personality and available resources. The criteria for evaluation of suicide potential follow:

1. Suicide plan: This is a significant criteria of suicide potentiality. Two main elements should be considered in appraising the suicide plan: (a) the lethality of the proposed method and (b) availability of the means. Hanging is of higher lethality than one which depends on the use of pills or wrist-cutting. If a gun is at hand, the threat of its use must be taken more seriously then when the person talks about shooting himself, or herself, but has no gun immediately available. In addition, if the person indicates by many details that they have made preparations, such as changing a will, writing notes, collecting pills, buying a gun, and setting a time, the seriousness of the suicidal risk rises markedly. Another factor in the rating of the suicide plan arises when the details are obviously bizarre. Further evaluation of the plan will depend in large degree upon the patient's psychiatric diagnosis. A psychotic person with the idea of suicide is a high risk and may make a bizarre attempt as a result of psychotic ideation.

2. Stress: Information about the precipitating stress usually is obtained in answer to the question, "Why are you calling at this time?" Typical precipitating stresses are losses, such as: loss of a loved person by death, divorce or separation; loss of job, money, prestige or status; loss of health through sickness, surgery or accident; threat of prosecution, criminal involvement or exposure, etc. Sometimes increased anxiety and tension appear

as a result of success, such as promotion on the job, and increased responsibilities. Stress must always be evaluated from the patient's point of view. What might be considered minimal stress by a worker might be felt as severe for the patient. The relationship noted between stress and symptoms (next criterion) is useful in evaluating prognosis. In general, if stress and symptoms are great, the action response of the worker must be high.

3. Symptoms: Suicide symptoms occur in many different psychological states. Among the most common are depression, psychosis, and agitation. Evidence of a severe depressive state may be elicited with questions about sleep disorder, loss of appetite, weight loss, social withdrawal, loss of interest, apathy and despondency, severe feelings of hopelessness and helplessness, and feelings of physical and psychological exhaustion. Psychotic states will be characterized by delusions, hallucinations, loss of contact or disorientation, or highly unusual ideas and experiences. Agitated states will be revealed by tension, anxiety, guilt, shame, poor impulse control and feelings of rage, anger, hostility and revenge. Of most significance is the state of agitated depression in which the person may feel unable to tolerate the pressure of their feelings and anxieties, and exhibits marked tension, fearfulness, restlessness, and pressure of speech. The patient feels they must act in some direction in order to obtain some relief from their feelings.

4. Resources: The patient's environmental resources are often critical in determining whether or not the patient will live. Inquiry should be made about resources which can be used to support them through the severe suicidal crisis. These may consist of family, relatives, close friends, physicians or clergy. If the patient is already in contact with a therapeutic agency or a professional therapist, the first consideration should be the possibility of

referral back to the therapist or agency. Another resource may be the patient's work, especially when it provides them with self-esteem and gratifying relationships. Related to this is the patient's financial status which may influence the availability and location of psychological care.

Sometimes the patient and family try to keep the suicidal situation a secret, or even deny its existence. As a general rule, this attempt at secrecy and denial must be vigorously counteracted and the suicidal situation dealt with openly and frankly. A general principle is that it is usually better both for the worker and for the patient when the responsibility for a suicidal patient is shared by as many people as possible. This gives the patient the feeling they lack, that others are interested and ready to help. Where there are no apparent sources of support, the situation should be considered more ominous. The same evaluation may be applied when resources are available but have become exhausted or hostile, as when family and friends have turned away and now refuse to be concerned with the suicidal patient. In most cases people respond to crisis and will help if given an opportunity to do so.

5. Life Style: This criterion refers to a stable versus unstable style of life and includes an evaluation of the suicidal behavior of the patient as acute or chronic. The stable person will report a consistent work history, stable marital and family relationship and no history of prior suicidal behavior. If serious attempts were made in the past, the current suicidal situation should usually be rated more dangerous. The unstable personality may include persons with repeated difficulties in the main areas of life functioning such as interpersonal relationships and employment. Acute suicidal behavior may be found in either a stable or an unstable personality; chronic suicidal behavior is found only in an unstable person. (Alcoholics, homosexuals and drug addicts tend to be high suicide risks.)

6. Communication Aspects: the communication aspects of the suicidal situation are revealing. The most important question is whether or not communication still exists between the suicidal person and other people. The most alarming signal is when communication with the suicidal person has been completely severed. This can be an indication to the worker that the suicidal person has lost hope of any possibility of rescuing activity.

The form of the communication may be significant. In any type, the communication may be either verbal or non-verbal, and, in content, it may be either direct or indirect. A serious problem in the suicidal situation occurs when the person engages in non-verbal and indirect communication. These "action communications" simply imply that the interchange between the suicidal person and others is unclear and frequently raises the probability of acting out of the suicidal impulses. In addition, if the recipient of the communication tends to deny the existence of things which upset them, it may be very difficult for them to appreciate or even recognize the suicidal nature of the communication. In general, one of the primary goals of the worker is to open and clarify the communication among all those who are involved.

The content of the communications may be directed to one or more significant persons in the patient's environment with accusations, expressions of hostility, blame, and implied and over demands for changes in behavior and feelings on the part of the other. Other communications may express feelings of guilt, inadequacy, worthlessness, or indications of strong anxiety and tension. When the communication is directed to specific persons, the reactions of these persons are important in the evaluation of the suicidal danger. These reactions are detailed in the following section.

7. Reactions of significant other: The significant other may be judged by the worker as non-helpful, or even injurious in the situation and, therefore, no possible assistance for the patient; or they may be seen as

helpful and significant resources for rescue. The non-helpful significant others either reject the patient or deny the suicidal behavior itself and withdraw both psychologically and physically from continued communication. The significant other may resent the increased demands, the insistent gratification of dependency needs, or the dictum to change their own behavior. In other cases, one may see helpless, indecisive and ambivalent behavior on the part of the significant other and the strong feeling that they do not know what the next step is and have given up. This latter reaction of hopelessness gives the suicidal person the feeling that aid is not available from a previously dependable source and may increase the patient's own feeling of hopelessness.

By contrast, a helpful reaction from the significant other is one in which the significant other recognizes the communication, is aware of the problem that needs to be dealt with and seeks help for the patient. This is an indication to the patient that their communication is being attended to and that someone is doing something to provide help.

8. Medical status: The medical situation of the patient may reveal additional important information for evaluating the suicidal potentiality. The patient, for example, may be suffering from a chronic, debilitating illness which has involved considerable change in self-image and self-concept. For persons with chronic illness, the relationship with their physician or health aide, their family, or their hospital or clinic will be of most importance. It is a positive sign if the patient continues to see these as resources for help. The patient may be suffering from ungrounded fears of a fatal or chronic illness, such as cancer, brain tumor, or substance abuse, and indicate a preoccupation with death and dying. There may be a history of many repeated unsuccessful experiences with doctors or a pattern of failure in

previous therapy. These symptoms are of importance because of their possible effect on the significant others and doctors, exhausting them as resources for the patient. In general, no single criterion need be alarming, with the possible exception of one: having a very lethal and specific plan for suicide. Rather, the evaluation of suicidal potential should be based on the general pattern of all the above criteria within the individual case.

For example, feelings of exhaustion and loss of resources might well have different implications in two patients of different ages. Thus, a 25-year-old married man stated that he was tired, depressed, and was having vague ideas about committing suicide by driving into a freeway abutment. There was no history of prior suicidal behavior. He reported difficulty in his marriage and talked of separation, but he was still in contact with his wife and was still able to work on a job that he had for many years. The risk here is low. A case of high risk is a 64-year-old man with a history of alcoholism who reported he had made a serious suicide attempt one year ago and was saved when someone unexpectedly walked in and found him comatose. He recounted a history of three failures in marriage, and many job changes in the past year. He further stated that his physical health had been failing, he had no family left and he was thinking of killing himself with a gun he had in his house.

D. Assessment of patient's strengths and resources:

It is as important to assess the patient's strengths and resources as it is to evaluate the pathological aspects of the picture. Frequently the patient will present alarming serious negative feelings and behaviors. These may be mitigated, however, by a number of positive features still present within the situation. For example, a good sign would be improvement in mood and thinking within the course of one interview as this indicates a person's ability to respond to offered help.

E. Formation of a therapeutic plan and mobilization of patient's and other's resources:

The plan formulated for the patient will be determined by the evaluation of the patient's suicidal status and the information obtained about the patient and their resources. In general, those cases with higher suicidal potential will require the most activity on the part of the worker. An evaluation of high suicide potential in a situation which appears out of control will usually require immediate hospitalization. Family or close friends should be contacted to help bring the situation under control and to take the patient to the hospital. They should be instructed not to leave the patient alone. However, many calls received by the worker are of low suicidal risk. Some of them can be handled satisfactory by simply providing sympathetic and understanding listening with telephone counseling and guidance.

Most cases, will require more action on the part of the worker, usually in referring the patient for further therapy, counseling, or other services. The type of referral will depend upon the evaluation of the problem. The referral may be to either a non-professional or a professional resource or to both. Although most calls or visits are not emergencies in terms of suicide, the individuals do have a serious life problem for which they need help. The suicide call is a "cry for help" with these problems.

If the call or visit comes at night, the worker should keep in mind that many problems are magnified during the night-time hours. An immediate goal would be to help the patient get through the night. The worker should strive to get sufficient information to determine if it is a high risk emergency requiring immediate action.

In the highly unusual event that a person is calling in the midst of their suicide attempt, as much information as is necessary to identify the patient or the caller should be obtained. Take the patient to an emergency hospital, call their personal physician, call an ambulance, or call the police. The aim at that time is to provide the patient with immediate medical attention.

At this point, it is important to note a critical aspect of the worker's responsibility. The worker might make a referral for the patient to one of the resources within the community, but the moral responsibility for the patient remains the worker's until this responsibility is assumed by the other resource. The patient is thus transferred rather than referred. The worker must not assume his responsibility has been discharged until they are assured that responsibility for care of the patient has been accepted elsewhere.

In general, if there is any question or doubt about the evaluation of the suicidal situation of the patient, they should be referred to a professional person for a complete evaluation. A patient with a suicidal problem that is not immediately serious but who presents emotional disturbances, may be referred to a psychiatric clinic, private therapist, family agency, or village health clinic. Frequently, such resources will require a waiting period and the referral to such agencies will depend upon whether or not the patient can sustain the interim period. A resource book showing available psychiatric and social agencies in the community is especially useful.

In suicide prevention, there will always appear, despite experience and knowledge, some cases which will arouse anxiety and tension in the worker. The most constructive way to handle these feelings is through informal discussions and consultation with colleagues which generally provide at least two measures of help. Not only is there a sharing of anxiety and

responsibility, but there is benefit from discussion of the problem. Regular meetings for training films, lectures by professionals who have had special experience, or case presentations help maintain morale and improve service. Comments on the problem cases of other workers should be directed toward evaluating the difficulties and offering constructive help. Every worker should be prepared for some failures. A recommended method of handling the grief experienced by workers when a suicide could not be prevented is to have a conference about the case in the spirit of mutual sympathy and support, and with the hope of learning more. In its many aspects suicide is still an enigma and there is much to be learned.

Resources: The following are detailed suggestions about general and community resources for use in suicidal situations. Any one or combinations of these resources should be considered as imaginatively and constructively as possible. The worker should not be constrained by conventional practices. In general, the resources will be of two types, non-professional and professional.

1. Non-professional resources:

a. Family. The family is often neglected as a resource but is one of the most valuable at the time of crisis. The patient should be encouraged to discuss their situation and problems with their family. If it is considered important that someone be with the patient during the crisis, the family members should be called and apprised of the situation even though the patient may be reluctant. The patient is usually informed first that their family will be called. Also, the family must be involved in accepting responsibilities for the emergency and in helping the patient get the treatment which has been recommended.

b. Friends. Close friends often can be used in the same way families have been used. For example, the patient can be encouraged to have a friend stay with them during a difficult period. The friend may also be helpful in talking things out and giving a feeling of support.

c. Family physician. People often turn to their family doctors for help and physicians often serve as supportive authority figures. The patient usually has a good relationship with their doctor and should be encouraged to discuss their problems with her or him. Physicians can also be helpful in cases where medication or hospitalization is required.

d. Clergy. If the caller is a member of a church they should be encouraged to discuss their situation with a minister of their faith.

e. Police. Police should be utilized in cases of clear and immediate emergency, e.g., if the suicide attempt is about to occur or has occurred. The patient may need prompt medical attention and the police are often the ones who can procure it most quickly. The police are able to take the responsibility for involvement with a patient and may hospitalize when necessary. It should be remembered, however, that the police are not to be used simply as an ambulance or transportation system. The police should be involved as a prime resource for anyone in trouble.

f. Emergency hospital The worker should be aware of hospitals available for emergency treatment.

2. Professional resources:

a. Own agency The worker may wish to refer the patient to their own agency in those cases where it is felt there is a high suicide potential and where there is a need for more intensive, careful further evaluation. Giving the patient an appointment gives the patient a task and a purpose in their immediate future. This resource, of course, can be used only when the agency includes facilities for personal interview and evaluation.

b. Social work agencies and community psychiatric clinics In those cases where the suicide danger has been evaluated as low or perhaps not even the primary problem, a referral to a family service agency or community psychiatric clinic can be considered. These are often the treatment medium of choice for patients in whom the underlying problem may be seen as marital discord, family conflict, or chronic personal and social maladjustment. The worker should be familiar with the social work agencies or community psychiatric clinics within his own community, or in nearby communities and referrals can be made to those near the patient.

c. Private therapist Some calls are from people looking for psychiatric treatment. The worker should be familiar with private therapists for appropriate recommendation in such cases. If the patient indicates that they are already in treatment, they should be encouraged to return to their own therapist.

d. Psychiatric hospital A connection with the nearest community that contains a general hospital with a psychiatric ward where patients can be hospitalized is most important. Generally, referral to such a resource is made when it is thought the patient is so disturbed that they might seriously harm themselves or others, and/or they are so disorganized they can no longer exercise judgment or direction of their affairs.

INTRODUCTION TO THE PHILOSOPHY AND METHODS OF HELPING ALCOHOLICS AND SUBSTANCE ABUSERS

INTRODUCTION

The philosophy and methods of "helping alcoholics" will be discussed in answer to four questions: (1) Who are we helping? (2) Who is the Helper? (3) What is helping? and, (4) What methods does the helper use in helping?

1. Who are we helping

In alcoholism rehabilitation there should be several target persons: the alcoholic, the problem drinker, the person who has a problem with alcohol, and the family members of these drinkers. As helpers our target group is broad in nature, as opposed to helping only the alcohol addict. In addition to the alcohol addict, this target group includes drinkers who are not considered alcoholics, but who have problems because of the drinking. It also includes persons who do not admit they are alcoholics, but do admit they have a problem with alcohol. The target population the alcoholism counselor must help includes the family members of all of the above types of drinkers. Without helping the family members we find it difficult to sustain help to the drinkers. In summary, our target population is broad in nature, rather than a narrow target which reaches only the alcohol addict.

2. Who is the helper

There are two types of helpers: the helpers whose motivation is to help themselves, primarily, while helping others, and the helpers whose motivation is primarily to help others, rather than themselves.

Every helper has reasons for being a helper. Some of these reasons may be "healthy" and other reasons may be "unhealthy." Everyone who attempts to

help alcoholics should look at their own motivation for being a helper and delineate the healthy aspects of helping from the unhealthy aspects. In other words, every helper should examine their reasons for wanting to help others, determine whether they are healthy or unhealthy, and overcome the unhealthy parts of being a helper.

Healthy Motivation

The helper who has healthy reasons for helping alcoholics is primarily concerned about the alcoholic as a sick person. Any personal needs for being a helper are placed secondary to the needs of the alcoholic and their family members.

Unhealthy Motivation

Many of the helpers of alcoholics have unhealthy reasons for helping. Their help to alcoholics is secondary to their need to help themselves or to further their own ends; or they may avoid helping the alcoholic because of their anger at the individual.

We can identify seven types of helpers whose motivation for helping alcoholics has unhealthy aspects to it:

a. The punishing helper

These are usually workers of public and social agencies who are annoyed or angry at the alcoholic because of their "self-inflicted" problem, and they do not want to help the client. They either push the person aside, or punish them in the act of helping them. Often this attitude is carried over into helping the spouse and children of the alcoholic also.

b. The over-protective helper

These persons want to help alcoholics, but assume an attitude of placating, parenting, or babying the alcoholic. They feel sorry for

the alcoholic and are often over-solicitous in their willingness to help. They often need to have someone weaker around them in order to feel strong and important. Some of them are described as "rescuers" who like to rescue alcoholics over and over again. Some may want to be the only helper in the life of the alcoholic and are jealous of anyone else who attempts to help.

c. The "A.A. Salesman"

Many "A.A." persons have healthy attitudes about helping alcoholics. However, some A.A. persons are primarily helping others attain sobriety in order to maintain their own sobriety in the helping process. In other words, their 12-step work is to help themselves, rather than to help the other alcoholic. In a sense they are like the high pressure salesperson who doesn't care about the customer, but is only trying to sell the product of A.A. and to feel the satisfaction of having sold something.

d. The Religion Salesman

Many religious persons have a sincere interest in helping other people; however, a minority of religious helpers are primarily interested in converting other people to their pattern of thinking and way of life. Again, like the salesperson, they have a strong need to feel the satisfaction of selling their product to someone without really caring about the other person. In a sense they are crusaders whose love of crusading is the primary reason for helping the alcoholic.

e. The Moralistic helper

These helpers are interested in doing away with drinking in our society - in a sense they want to clean up society out of their own

need for "the pure life," rather than a concern for an alcoholic as a person. This person will often use "scare tactics" as a means of attempting to get people to stop drinking.

f. The "Friend" helper

These alcoholics have a personal investment in the alcoholic stopping drinking as though it is "do it for me." As with other types of unhealthy helpers, they put the friendship on the line and will reject or punish the alcoholic if he or she doesn't satisfy their need to have them stop drinking.

g. The "Professional" helper

Many professional people are interested in making money through helping people. Again, many of them don't want to help alcoholics, but will tolerate them and work with them because they are part of the case load and the "day's work." They, like some of the other unhealthy helpers, are "only earning a living" and don't really care about the alcoholic and their family.

Every "helper" should examine their reasons for wanting to help others. They should look at the unhealthy aspects of their motivation and become aware of these and consciously attempt to discipline their own needs and put them into the background. The needs of the alcoholic and their family should be the helper's primary interest and any personal need to help others should become secondary in the helping process.

3. What is helping

There are two definitions of helping that are appropriate in helping alcoholics: helping the alcoholic and their family members help themselves, and helping the alcoholic and their family members make a better adjustment. The major emphasis in the first definition is keeping the alcoholic's problems

on the client's shoulders and assisting with problems rather than assuming them for the client. The major emphasis in the second definition is on helping the alcoholic improve their lot in life only enough to "function" rather than trying to "make them over."

Philosophy of Helping

There are three major aspects underlying the philosophy of helping that need to be emphasized: 1) gaining an understanding of human nature and of helping methods, 2) adopting the "sick person" concept in helping, and 3) adopting the "whole person" concept in helping.

Every helper should understand as much as he or she can about human nature. There are many models proposed to help the helper understand about human nature. The model adopted by this training program is the "inner and outer forces mode." This model theorizes that behavior is the result of a set of inner forces and a set of outer forces, playing upon the individual. It is assumed that the helper, on analyzing the inner-outer forces playing on the alcoholic and their family members will be better able to help them find a solution to their problems.

The "sick person" concept claims that the alcoholic is a sick person. It also implies that the alcoholic comes from a "sick family." Further, it implies that the alcoholic is caught up in a "sick environment." Consequently, this concept implies that the helper needs to help the alcoholic and their family and their situation toward a better adjustment. The worker places heavy emphasis upon helping the family who is out of adjustment, and upon helping the alcoholic and their family improve their circumstances.

The "whole person" concepts implies that the alcoholic has various parts to them, i.e., physical, mental, social, and vocational parts. When the alcoholic is viewed as a "whole," each of these aspects of life need

straightening out. It is the responsibility of the helper to investigate each of these aspects of the alcoholic's life and to help find a way of adjusting them.

The Helping Process

The helping process consists of about six steps. They are described as follows:

1. Getting acquainted with the alcoholic, and their situation
2. Developing a rapport with the alcoholic or person
3. Helping the person or individual with their physical needs
4. Meeting the emotional needs of the person
5. Helping the person achieve a healthier personal, social, and vocational adjustment
6. Support the person in their desire to become sober

Developing a Rapport

A helping relationship needs rapport to be effective. No needs of the client can be met without first gaining rapport. Gaining rapport can be done by following these guidelines:

1. Individualizing the client
2. Accepting him/her as a person of worth
3. Allowing the client to ventilate and express their feelings
4. Not judging nor condemning the client
5. Permitting the client to make their own choices and decisions
6. Keeping information the client gives you STRICTLY confidential

4. What methods does the Helper use in Helping

The helper uses two methods in the helping process, 1) use of her or himself, and 2) use of community resources.

Use of Self

Too many helpers do not want to use themselves, but insist upon finding someone else to help their clients. They consider this the helping process. However, many of the sources of referral in the community do not want to help the alcoholic, who is then no better off than before being referred. Also, many helpers "dump" the alcoholic through referral, dropping such a client from their caseload as though they have done their job.

If the helper is to be a true counselor, it is necessary to develop counseling techniques and to work with the alcoholic through one's own skills of helping, using community resources when called for. The counselor should learn individual counseling techniques, group counseling techniques, and family counseling techniques, and apply these methods to casework with the alcoholic and their family members.

Use of Community Resources

It is necessary to use community resources in helping alcoholics because "no one can be all things to all people." The alcoholic may need personal or marriage counseling, medical assistance, and vocational help. It is difficult to find a helper who is competent in all of these areas. Consequently, it is important for the helper to refer the alcoholic and their family members to other resources in the community when these needs arise. The important thing to remember is that the alcoholic and their family members may need help in getting to the community resource and the community resource may need help before they will receive the alcoholic and their family members properly. The helper should realize there should be a "before and after" to each referral to community resources. This means the counselor must work with the alcoholic and their family members before the referral and continue to work with them while they are involved with the referring agency and after they have finished

with services from these agencies. In this way, the helper provides continuity and ongoing services, maintaining the alcoholic and their family members until they have recovered or achieved better adjustment.

DRUG INFORMATION

Drug information questions are usually not emergencies, but sometimes what sounds like a casual information question may actually be an emergency. Attempt to find this out at the beginning. Poison Control will be your best source of specific drug information.

This section on drugs is not intended to tell you everything you need to know about drugs, but is a summary of drugs and their effects.

HALLUCINOGENS

Names: LSD, DOM, STP, psilosybin, mescaline, peyote, DMT, MDA

Slang: acid, microdot, window pane, blotter, double domes, mesc, orange sunshine, purple haze, pink lady, flats, osley, cubes.

General effects:

- dilated pupils (not all)
- rise in body temperature
- slight rise in blood pressure
- altered perception, especially time and space
- enhanced colors
- hear color and see sounds
- may feel overwhelmed by auditory and visual stimuli
- impaired body coordination

- rapidly changing emotions
- feeling of being inside and outside oneself at the same time

Effects of misuse:

- intense anxiety
- panic
- depressive and paranoid reactions
- large mood changes
- inability to distinguish between fantasy and reality
- flashbacks (recurrence of drug-like effects after a drug-free period)
- possible danger of birth defects

Hallucinogens are different from other drugs of abuse because they primarily effect the mind, not the body. Most of the hallucinogens sold on the street are actually LSD, so most of the following discussion refers to LSD. A lethal overdose of LSD is very unlikely; however, it is possible that a person may take what might be termed a psychological overdose. When cut or poorly synthesized, it is possible that the impurities could make the user quite ill. "Mind" drugs do have tolerance levels and cross-tolerance between the various hallucinogens do exist; however, physical dependence does not seem to occur so withdrawal symptoms do not occur. However, because many of the hallucinogens are chemically related to the amphetamines, a person can exhibit psychological and emotional symptoms after use (post-crash depression). Tolerance is requiring more of the substance to acquire the same effect as the drug is used over time. Physical dependence is becoming physically sick if the substance of abuse is stopped abruptly. Psychological dependence is experiencing craving or the desire to have the substance of abuse. One can be psychologically addicted without being physically addicted.

BAD TRIPS

The care of bad reactions to hallucinogenics is divided into two areas: First, dealing with the bad head trip and second, handling the bad body trip. Often both of these aspects complicate the situation by occurring at the same time. These reactions cannot usually be brought under control quickly.

Bad head trips:

Anyone can have a bad trip -- it is by no means an indication that a person is crazy or has underlying psychological disturbances. A bad trip can be triggered by being separated from friends, having a fight with someone, doing badly in school, or just being depressed about life. The environment (loud music, bright lights, feelings from other people) can cause bad reactions.

A. Talkdown

One essential element in a talkdown is being reassuring. BE CALM YOURSELF. Trippers are quite aware of non-verbal messages. Any panic displayed by you will be read by them and will only reinforce their fears. Excessive questioning, moralizing, or anxiety on your part will make the situation worse. Do not feel compelled to make sense out of the verbal content for trippers. Keep an open mind about their feelings and behavior so they can feel comfortable relating the experience to you. Encourage them to talk. Respond simply and honestly. Even if the tripper is totally uncommunicative, it is important for you to stand by with a warm, calm presence. Be verbally, but quietly, reassuring.

It sometimes helps to have the caller or someone present with the caller cut down on the stimuli in the environment: turn down lights, play softer

music, clear the room of everyone but a friend or two the caller trusts.

When talking to people who are tripping you may be their only link with reality. You may have to establish bridges to reality for them. These bridges will probably be things that are physically present with callers, such as:

- a stereo. Have them listen to their favorite music.
- a television. Trippers sometimes like to watch with the sound off; have them describe what they see.
- the telephone -- it's real, hard, colorful. It has numbers and letters. Get them to describe it.

As the conversation continues, if the person sounds clearer, more relaxed, or generally better, tell them so. Humor is a very good technique after a conversation has been established. It relieves tension, anxiety, and panic feelings for both the listener and the tripper. Remind the individual that if there is discomfort it is chemically based and that soon the drug will be metabolized.

Things to avoid

Never lie about even the smallest thing; they will pick it up immediately. For example, if you don't know anything about LSD and the caller asks you something about it, tell the truth but emphasize that you will try to relate to her/him as best you can.

Your role as a Crisis Management Specialist is not to moralize or ask questions about why the caller has taken the drug. Never recommend taking another drug to help the person come down. Remember, the bad tripper needs warmth and human contact, not psychoanalysis.

Never assume because a person is tripping that she/he is having a bad time. The individual may just want to talk and such an assumption on the Crisis Management Specialist's part could turn a good trip into a bad one.

Bad body trip:

A bad body trip includes physical discomfort and signs of a toxic reaction, which may be due to impurities in street drugs. These reactions are not uncommon in hallucinogenic drugs and are not necessarily cause for worry. The best method of dealing with these symptoms (nausea, headache, muscle pain) is to communicate to the point of distracting attention from the physical discomfort and dealing with the mind portion of the trip. At the same time, it is important to watch for other signs that may indicate deterioration of the individual's condition or more serious maladies, such as perforating duodenal ulcer, appendicitis, etc. Never be afraid to refer to medical back-up for information.

There are two drugs which are chemically unlike other hallucinogens but have similar effects. PCP, the most common is described below:

PCP (phencyclidine, but sometimes sold as THC, the active ingredient in marijuana)

Slang: PCP, tic, tac, THC, Peace Pill, Angeldust, crystal, Crystal Joint, Dust, horse and dog tranquilizer

The caller may also experience one or more of the following reactions:

1. person may become violent
2. person may develop great strength for a short period of time
3. person may have short-term memory loss

Effects of misuse:

Small doses
- numbness of hands and feet
- lack of coordination
- increased heartbeat
- can cause relaxation or panic and paranoia

Moderate - sleepiness
- kills pain
- sometimes mild hallucinations
- muscular rigidity and disorientation
- eye balls jumping around (nystagmus)

Large doses - increased numbness
- dizziness
- seizures are possible
- nausea and vomiting sometimes lasting for days
- double vision
- confusion about time and space
- hallucinations
- convulsions can cause death
- inability to move or communicate

Description:

This drug's effects are unpredictable. The same dose may affect two users in entirely different ways or may affect the same person differently on separate occasions. Though psychotic reactions rarely occur, users often become confused and anxious because they lose contact with their extremities. If someone has taken a low dose, follow the same procedures for talk-down that you would for a hallucinogenic drug. Reduce sensory stimuli in the environment and establish links with reality. If the caller has taken a large dose and is convulsing, waste no time getting them to a hospital.

Mode of Ingestion:

The most common method of use is to mix the PCP with another substance like tobacco or mint leaves and then smoke it in a joint. It may be snorted, injected, or ingested.

MARIJUANA AND HASHISH

Slang: grass, weed, pot, hash, reefer drops, tea, hash oil, mary jane, reefer, bud (puna, kona, etc.)

General effects:

- redness of eyes
- dry throat
- increased pulse rate
- relaxation and euphoria
- user can become "spacey"
- high dose use by inexperienced user may lead to impulsive behavior and anxiety
- user often has "munchies"
- a lethal dose of marijuana is almost unattainable

Description:

The primary active ingredient in marijuana and hashish is tetrahydrocannabinol (THC). Loss of coordination and reflex can be similar to that of alcohol use, so driving automobiles and operating machinery is not advised. Rare cases of panic or anxiety with marijuana use can be handled similarly to hallucinogenic trips -- reduce stimuli, calm the person down, rap for a while etc. Long term, heavy use may lead to apathy or loss of motivation.

STIMULANTS

(uppers)

AMPHETAMINES

Names: amphetamine, methamphetamine (Methedrine), dextroamphetamine (Dexedrine), amphetamine sulfate (Benzedrine), Ritalin, caffeine, Ephredrine.

Slang: uppers, speed, bennies, pep pills, footballs, subs, white cross, black beauties, L.A. Turnarounds, christmas trees, pink hearts, cross-tops.

General effect and medical uses:

- to lose weight (suppresses appetite)
- to increase pulse rate and blood pressure
- to overcome sleepiness and fatigue
- to reduce hyperactivity in children (Ritalin)

Effects of misuse:

- restlessness, nervousness, agitation, talkativeness
- feelings of irritability and paranoia
- high doses of amphetamines can cause convulsions
- tolerance develops rapidly which may cause the person to use higher and higher doses
- impairment of judgment
- prolonged moods of depression (especially after discontinued use)
- increased pulse rate
- unclear speech, dilated pupils
- people sometimes talk in sentence fragments and don't make much sense
- can trigger psychosis in some people

Some people, after using large amounts of amphetamines go through what is known as toxic psychosis. Symptoms include: fear, terror, delusions, hallucinations, high anxiety, and paranoia. If someone is experiencing this psychosis refer him/her to the hospital for treatment.

Overdose:

A person who has taken a toxic dose of amphetamines would be near unconsciousness, have a high pulse rate, display signs of shock, have a high fever, and possibly have convulsions. GET THE VICTIM TO THE HOSPITAL IMMEDIATELY.

COCAINE

Slang: coke, snow, rich man's drug, toot, girl, white lady, blow, snort

General effects:

- central nervous system stimulant

Length of effect:

- this is a short acting drug; the effects generally last no longer than one to two hours

Mode of ingestion:

- most commonly snorted but can be smoked (free base), and sometimes injected

Effects of misuse:

- effects similar to that of amphetamines
- raised body temperature
- accelerated pulse
- quick, shallow breathing
- snorting and sniffing can cause nasal congestion and breakdown of nasal tissue
- disgestive disorders, headache, and nausea
- loss of appetite, irritability, insomnia
- psychological dependence and habituation develops since the experience is intensely euphoric

- toxic psychosis can result (see amphetamines)
- depression often occurs after the effect of the drug wears off

Overdose:

Initial symptoms include abdominal pain, hallucinations, chills or fever, vomiting, numbness and muscle spasms, followed by depressed and irregular respiration, convulsions, coma, and circulatory failure. Death may occur immediately after ingestion of the drug or may be delayed 1 to 3 hours. If any of these symptoms are displayed by a person who has taken cocaine, HAVE THE PERSON TAKEN TO THE HOSPITAL.

DEPRESSANTS

BARBITURATE AND NON-BARBITURATE HYPNOTICS

Names: Secobarbital, Seconal, Amobarbital, Phenobarbital, Nembual, Doriden, Tuinal, Amytal, Butisol sodium, Chloral hydrate, Placidyl, Valmid, Dalmane, Methaqualone, Quaaludes, Sopor, Parest

Slang: reds, red devils, sopor, quads, 'luudes, downers, barbs, yellow jackets

General effects and medical uses:

These drugs are central nervous system depressants and are used to calm people down, induce sleep, and control epileptic seizures.

Effects of misuse:

- symptoms of alcohol intoxication
- euphoria, talkativeness, slurred speech, loss of inhibition, faulty judgement
- drowsiness, disorientation
- large doses lead to sleep, lowered blood pressure, lowered pulse,

lowered respiration, overdosage proceeds from respiration failure to death

- downers are also physically addicting and if the person is addicted to downers and has discontinued them, withdrawal will occur. Withdrawal from downers can be deadly. If a person is addicted to downers and wants to stop it will have to be done medically, under a doctor's supervision.
- ACCIDENTAL DEATHS from overdoses of barbiturates are common because abusers become confused as a result of the effects of the drug and forget how many they have taken, or combine barbiturates and alcohol.

What to do in case of overdose:

It is important to determine:

1. what drug or combinations of drugs were taken
2. how much was taken (mg. of barbs, oz. of alcohol)
3. when (time) and by what means (injected, swallowed) they were taken

In the case of an overdose or suspected overdose with quaaludes, the person must be monitored for 24 hours. Quaaludes are metabolized in the liver and a person may appear to be improving but hours later the quaaludes can go back into the blood stream causing convulsions and/or respiratory failure.

TRANQUILIZERS

Minor tranquilizers: Librium, Valium, Dalmane, Serax, Equanil, Miltown, Vistaril, Atarax, Benadryl

Major tranquilizers: Thorazine, Compazine, Mellaril, Sparine, Stelazine, Prolixin, Haldol

Medical use and general effects:

- central nervous system depressants

- decrease anxiety
- sedative action
- muscle relaxant
- control psychosis (major tranquilizers only)

Effects of misuse:

- drowsiness, fatigue
- confusion
- dizziness, headache
- slurred speech
- possible weight gain
- dryness of the mouth
- possible tremors and convulsions
- constipation
- lack of coordination
- blurred vision (some)
- these drugs are potentiated by alcohol (beware of mixing the two)
- some may aggravate epilepsy and seizures
- dangerous to unborn children (some)
- physical addiction can occur and withdrawal is the same as for barbiturates (potentially deadly)

What to do in case of overdose (minor tranquilizers only):

In case of overdose refer to Downers section on overdoses. Vistaril, Atarax, Benadryl, Librium, Dalmane, Valium, Serax overdoses are similar to quaalude O.D. The person must be monitored for 24 hours.

It is very common for people to mix alcohol with other drugs. While it is possible to overdose on alcohol alone, most overdoses involving alcohol are due to combinations. Alcohol potentiates the effects of other depressants. A rule of thumb for assessing the lethality of a drug/alcohol overdose is that

alcohol will multiply the effect of the drug by a factor of three. If a caller has taken 200 mg. of seconal with some beer, the combination could potentially have the effect of 600 mg. of Seconal.

Amphetamines can mask the effects of alcohol and cause a person to accidentally take an overdose of alcohol.

Alcohol overdose:

In an overdose of alcohol the person will have very depressed body functions, coma, and respiratory failure. GET THE PERSON TO A HOSPITAL IMMEDIATELY.

Withdrawal:

Withdrawal from alcohol is similar to withdrawal from barbiturates and tranquilizers. Three to six hours after the last drink, an alcoholic may experience shaking, vomiting, cramps, anxiety, sweating. Twenty four to forty-eight hours later delirium tremens sets in. DT's include hallucinations, increased temperature, convulsions, uncontrollable shaking. If someone is experiencing DT's, GET THEM TO THE HOSPITAL IMMEDIATELY. Acute alcohol withdrawal can be deadly.

NARCOTICS

Names: opium, codeine, morphine, heroin, methadone

Slang: horse, junk, smack, jones, skag, scat, H

General effects and uses:

- central nervous system depressant
- pain killer
- relief from cough

Effects of misuse:

- lethargy, drowsiness, apathy
- reduced motivation

- anxiety, insomnia
- euphoria
- slowness of breath
- heaviness of limbs and itchiness of nose and face
- pin point pupils
- physical addiction -- withdrawal occurs
- possible nausea and vomiting
- danger of overdose
- complications of needle use are common

Overdose: Narcotic overdose is indicated by:

1. Respiration below 14 per minute
2. Pin-point pupils
3. Unconsciousness

When an overdose of a narcotic occurs, every second counts. GET THE PERSON TO THE HOSPITAL IMMEDIATELY.

Withdrawal:

Withdrawal from narcotics is an agonizing, but rarely lifethreatening, illness. It usually lasts from 3 to 5 days and is characterized by these symptoms: agitation, abdominal and muscle cramps, vomiting, diarrhea, shivering, and sweating. Treatment in a clinical setting is recommended, and people who are withdrawing should not be left alone, since they could choke on their vomit.

INHALANTS

Name: benzine, gasoline, paint thinner, lighter fluid, airplane glue, PAM butane, spray paint, amyl nitrate, nitrous oxide

Effects of misuse:

- euphoria, alcohol-like intoxication

- rapid central nervous system depression after sniffing
- dizziness
- breakdown of inhibitions
- visual hallucinations
- lack of judgment (can lead to dangerous accidents, fights, and other threatening situations)
- early deterioration of liver, kidneys, brain cells and connective tissue
- sudden death (not at all uncommon because of the poisonous nature of many of these substances)
- possible a high pulse rate
- personality changes due to prolonged use

If someone is unconscious after inhaling one of these substances, GET THEM TO THE HOSPITAL IMMEDIATELY. These substances can sensitize the heart to adrenalin. It is imperative that the user remain calm and quiet. Excitement can lead to heart failure.

INCEST

Incest--some turn away from the word, joke nervously, or stop short, experiencing a mixture of curiosity and horror. It is estimated that 85 percent of all sexual assaults of children are by family members or friends; one-fourth of all American females have been sexually abused. We warn children to stay away from strangers, but our own fears, prejudices and secrets prevent us from adequately protecting them from daddy, Uncle Fred, cousin Tom or mom's boyfriend, Sam.

Often we unconsciously set our children up to be victims by giving them certain messages about sex and their rights. We have taught them to respect and obey adults without question, to distrust strangers, while trusting family members and friends. Yet it is the naive trust and obedience that allows children, both male and female, to become victims of sexual abuse.

The closer the relationship of the child to the adult, the more traumatic the emotional impact of the incest can be. What may start out as a game, or a genuine display of affection on the part of the child turns into an exploitation of the child's trust by the adult. Daddy asks her to feel his penis and says it's okay, but something tells her it is wrong. She is confused - daddy is the grown-up and must be right, but he said not to tell Mom....if it's okay why is it a secret? So begins the erosion of the child's self-esteem as she doubts her own perceptions and feelings.

Children in our culture are bombarded with the message that sex is power. They learn early that their sexuality is a valued commodity. Being pretty earns young girls many favors. Henry Giaretto of the Santa Clara County Sexual Abuse Project in California notes that "...we teach our girls to be Lolitas and sexual provacateurs from the time they're two. They get it from

television continually; how to flounce their hair, how to shake their butts. But what we don't teach them is that they have a right to say no, a right to keep their bodies private."

Sandra Butler, in her book, Conspiracy of Silence: The Trauma of Incest, defines incest as "any manual, oral or genital contact or other explicitly sexual behavior that an adult family member imposes on a child by exploiting the child's vulnerability and powerlessness." A child cannot freely consent to having sex with an adult because he or she does not have the information, ability, or maturity to make that decision. A normal father may have sexual feelings toward his daughter, especially as the girl enters adolescence, but recognizes that he does not have to translate his feelings into action. He find appropriate ways to meet his sexual needs.

Cases of incest cut through all racial types, income levels, so-called broken and intact families, and all religions.

In Alaska, many incestuous families can behave well in front of outsiders. Assistant District Attorney Gayle Horetski handles most sexual assault cases for the South Central region of the state. The families she sees are predominantly white, middle class, average wage-earning families. Horetski describes the fathers as either strong and domineering, or passive and inadequate. The mothers are usually passive; dependent on their husbands for financial and emotional support. The victims are often intelligent, independent, mature for their years, and often streetwise and sexually active.

Pam Kirk, therapist with the Human Relations Center, a private agency specializing in treatment of incestuous families, says that 80 percent of the parents at the center fall into the super-mom or super-dad categories. One parent is overly responsible and the other functions more like one of the children. Fathers generally have a low self-image, a strong need to be nurtured, and have had poor relationships with their own parents.

Researchers such as Blair and Rita Justice, authors of The Broken Taboo, describe the majority of incestuous fathers as men who feel inadequate and have strong needs for warmth and affection, but do not know how to meet those needs in non-sexual ways. "Most men who commit incest are completely out of touch with their needs and have experience meeting them in healthy ways."

Externally they may be quiet, shy, introverted, or at the other extreme, a tyrant, strong and protective, but inside they want to be taken care of. A "mothering" wife may meet those needs for a while, but a family crisis such as loss of employment, his wife going to work, an unresolved marital crisis, or a major geographical move may be enough to upset the family balance and cause him to seek affection and security from his daughter; someone unable to challenge his adequacy.

Many myths blur the reality of incest and perpetuate the belief that it only happens to other people. One common myth is that incest is committed by men who are seriously mentally ill. A few men who commit incest may be psychotic, or they may be pedophiles--they feel a sexual attraction to all children--but the majority of the offenders do not suffer from any severe mental illness.

Many people assume that most incest victims are teenage girls.

Nationally the average age of the incest victim is 11 years old. Most incest starts before a child reaches adolescence and may begin with touching and overstimulation, and progress to fondling and intercourse over a period of years. David Teal, a caseworker with the Division of Family and Youth Services in Anchorage reports that the youngest suspected case of sexual abuse he has seen was a three-year-old boy. Most of Teal's cases span the 10 to 16 year-old range. Others workers report victims as young as 18 months old.

Although most victims who come to the attention of the authorities are girls, there are a growing number of male victims abused by male family members. There are few reported incidents of mother/son incest.

Physical force is used in some incest cases, but more often there is a subtle coercion, such as threat of force, threat of breaking up the family if the child does not comply or "tells the secret," or a distorted appearance of conveying affection.

It is true there are some mothers who would rather their husbands have sex with their daughters than themselves and either openly encourage the incest or passively allow it to happen. Other mothers, however, may have no idea that the incest is happening, or because of lack of education or insight, simply may not recognize the signs.

Speculation on why incest occurs has been hotly debated. Feminists such as Sandra Butler, and Florence Rush, author of The Best Kept Secret, point to the use of children as sexual objects, as a manifestation of the destructive effects of a male dominated society. They see incest as another vehicle by which men continue to victimize females. They believe the solution to this problem can only come about when women gain equal power with men and can protect themselves and their children. Treatment from this viewpoint focuses on protecting the victim and prosecuting the offender as a child molester or rapist.

Many professionals believe, however, that incest is a symptom of broader problems within a family, such as lack of communication among family members, poor parenting, or a poor marital relationship. Yet not all family problems lead to incest. The Justices claim in their research that incest results from the interplay of social, economic, community, family, and individual factors. In other words, the attitudes held by society on sex roles, sexuality, and the

rights of children, combine with specific pressures on families such as unemployment, isolation, and role changes, to incubate the incest. Counselors focus on helping the family become more emotionally healthy and providing them with skills to cope with the stress and transiency of their environment.

In the past, therapists, police officers, and child protection workers were often acutely ignorant of the signs and dynamics of incest. If they did encounter a case they were powerless to solve the problem in any other way than removing the child from the home or jailing the offender. These options, although at times appropriate, only served to heap more guilt on the child. Now through the educational efforts of established sexual abuse programs such as Harborview in Seattle, and Santa Clara in California, social service workers offer more support to families and hold the sexual offender accountable for his actions.

In the cities and bush areas of Alaska, people in the helping professions have long seen the cumulative effects of incest in teenage prostitution, promiscuity, pregnancy, suicide, and drug involvement. The boom and bust history, continual influx of new residents who pull up stakes and arrive with no extended family or support system, the high rate of unemployment, and harsh physical environment leaves Alaska ripe for an incest epidemic. In a state leading the nation in rates of alcoholism, child abuse, rape, and all types of violence, incest is the social problem most reluctantly dragged out of the closet. "Stop incest" is not a popular campaign slogan.

No one knows for sure how much of an incest problem Alaska has because no statewide system exists to collect statistics. Also, in the past, child sexual abuse has not been separated from other forms of child abuse, or other sexual offenses. A new statewide computer system may bring some numbers in the near future. Meanwhile, Horetski reports that she has had a four-fold

increase in her caseload since 1981. This is partially a result of a new cooperative policy of cross-reporting for sexual abuse cases between the Division of Family and Youth Services and the Anchorage Police Department. David Teal, who has an 80 percent caseload of child sexual abuse, describes an overload of incest reports to his department and the need for more workers. In a six-month period from October 1981 to March of 1982, there were 69 new cases reported to the Anchorage office alone.

In small Alaskan communities a lack of treatment resources for incest victims and families has been a frustrating fact of life. In some areas, jail for the offender, or foster home for the victim are still the only options available to interrupt the incest.

Janet, age 34, lives in Anchorage. She has just spent the most difficult year of her life pulling together a family that was shattered after her daughter reported incest.

Marie comes from a long-time Alaskan family. Her daughter, Rita, 13, was a victim of incest. Rita's father had been sexually abusing her almost every night for a year and a half before she told a friend about it.

Kathryn is a Tlingit woman from a small village. As a child she was sexually abused by several different family members over a period of years.

Each of these Alaskan women has a unique story of how incest led to the break-down and rebuilding of their lives. As varied as their backgrounds are they have shared some similar struggles. Each one has dealt with a distrust of men, problems in communicating with their daughters, and all have considered suicide as a result of their experiences. Most importantly, all have had trouble recognizing that they had choices in their lives.

"It was like being told I was going to die," Janet said quietly. "I refused to believe it." Nearly a year ago, Janet's daughter Sandy reported her father for incest.

"I thought she made it up to get even with me for something," said Janet. Her denial crumbled, though, when her husband confessed during the police interview. "It was like I had been hit in the gut and all the air forced out," she said.

The second of five children, Janet was physically and emotionally abused as a child by an alcoholic father. When she was 10, her father gave up both his drinking and abuse, but his sobriety forced her brother to reluctantly give up his place as head of the family. Five years older than Janet, he chose her to be the target of his hostility, confusion, and disappointment over the loss of his position in the family. For three years he sexually assaulted Janet repeatedly and she told no one.

At 19, when Janet married Jerry she was certain she had chosen a man who was different from her father and her brother. He was quiet, soft-spoken, gentle, and didn't drink. They were both lonely--he had come from a large family with extremely religious parents and never measured up to the high standards they set up for him. Janet was afraid of men and found Jerry kind and friendly. She was warm and gave him the affection his parents were unable to show.

Externally, Janet trusted Jerry, but after the birth of their daughter she harbored a never-spoken fear that Sandy would be raped as she had been. When Janet's worst fears were confirmed she was engulfed in a flood of hopelessness and guilt.

She had been a good military wife, a super-mom who successfully took care of her children and husband and made most of the decisions in the family.

After 14 years, she considered her marriage to be relatively happy, safe, and predictable, but she had made some changes in herself. After several years of staying home with her two children, she had lost 40 pounds and had gone to work as a bookkeeper, with hopes of earning enough money to go back to college.

Looking back, Janet realizes that there were problems all along. Jerry had a hard time with her growing independence, and she had never had much confidence in his judgment or the decision he made. Her childhood experience with abuse made her wary of affection from men. Both she and Jerry had trouble asking each other for what they needed and didn't know how to express anger.

Janet's daughter and husband had always had a close relationship--they were physically close and did things together. Janet noted a change in them when Sandy quit giving her dad a kiss goodnight. "Jerry wanted affection from Sandy, not sexual fulfillment," Janet maintains. "He could have gone to another woman for that, but the only way he knew how to ask for love was through sex."

Janet's normally soft voice becomes brittle as she recalls the rage she felt toward Jerry for his betrayal of her trust, the rejection she feared from her family and friends, and the dilemma of feeling forced to choose between her husband and daughter.

Jerry did not go to jail for the sexual abuse of his daughter. He is now on five year probation. If family therapy goes well, he will be allowed to return home to live with his family soon. Janet says their marriage is different now--better. She and Jerry pay more attention to each other and can talk. Their relationship is more equal. Janet is more willing to share with him and has quit trying to be his mother. She trusts him for perhaps the

first time in their marriage. She also feels less emotionally dependent on him, and more confident about herself.

Janet no longer feels guilty about what happened. "I was the best wife I knew how to be," she says. "All I knew was how I was raised."

Marie is tall with dark hair, a large woman. She speaks with an ease and confidence that comes from having told her story many times before. She has changed a lot in two years, has even become a sponsor with Parents United, helping other mothers through the desperation of the first weeks after the incest is revealed. Her personal struggle has been with her own insecurity and self-doubt.

It happened imperceptably over the years. Marie was quiet, accommodating, lacking in confidence, with a tendency to be unorganized. Her husband worked on the slope and she had trouble managing the house and three children alone. Rita, her oldest daughter, was aggressive, active, organized, a fighter. Marie tried to protect Rita from conflicts by mediating, but that only made things worse. Marie grew less and less confident of her abilities as a mother, and eventually Rita, barely 13-years old, was running the house and telling her mother what to do.

Marie didn't recognize that there was more to the battles between her husband, Ken, and Rita than their mutual stubborness or Rita's adolescent rebellion. Marie questioned Rita's request for a lock on her bedroom door, but dismissed her own suspicions. After all, she and Ken had a good sex life and her daughter was only 13. But something was wrong.

Ken was leaving Marie after she went to sleep at night to creep into Rita's room and fondle her. Rita was afraid to tell her mother because she didn't think Marie would believe her. Instead, she told a friend whose mother finally made the report. Rita was surprised and relieved to learn that her

mother believed her. Marie was hurt that Rita did not tell her first and ashamed when the police and social worker invaded the family's privacy. "In some ways a family death would have been easier," Marie said. "You wouldn't have to worry about what others think."

Ken was forced by court order to live away from home and have no contact with Rita except during therapy sessions. Marie was angry at first, and couldn't understand why he had to stay away since he admitted the incest and was in therapy. Now, she is relieved that they had time apart. It was easier for her to be assertive without him there, easier to say things to him on the telephone than in person. She also felt guilty about not divorcing Ken - was afraid that her family, friends, and Rita would expect that of her. But there was the reality of her inability to support herself and the kids on her own, and the fact that she did not want to leave Ken.

Rita, who gave up her maternal role in the family grudgingly at first, now acts more like a normal 14-year-old girl, although some of her friends are still older than she is. Rita has become active in sports, music, and school. After months of therapy with her dad, the battles between them are of a normal adolescent quality and their relationship has improved.

Marie feels confident that the improved communication between herself and Rita, along with Ken's experience with the criminal justice system and the improvements in their marriage will prevent the incest from occurring again. She has two lessons to impart to other mothers from her experience. First, "Have an open relationship with your daughter so that she feels you will believe her if she tells you." Second, "You have a choice - you have a right to say no."

"Sometimes," Kathryn says, "I still feel like I'm eight years old. People say they care but then they hurt me. I don't believe them. I don't trust adults."

When she was eight years old Kathryn was sexually abused on several occasions by an uncle and cousins. Alcohol was always involved. Her mother was an alcoholic and, although Kathryn had a good relationship with her father, he left the family when she was seven. From that age she lived with various relatives, spent time in foster care, and spent her teen years in a juvenile correctional facility outside of Alaska.

Kathryn is 35 now, and speaking in a direct and determined voice, she conveys the appearance of great strength despite her slight body. She is raising her two children on her own and is economically and professionally successful, but there are glimpses of the little girl inside. She is proud of her culture, but still angry at some of her family members. She learned early to build a tough exterior shell to protect herself emotionally since she could not protect herself physically. But the shell has had its costs. Now she yearns to be close to people but she does not know how.

As a "pretty little girl", Kathryn learned that she was "special" in her family, and that her sexuality was a valuable tool to get what she wanted. As a woman, she admits that she has manipulated the many men who have gone through her life.

As Kathryn's daughter turned eight years old, she panicked as she saw a reflection of herself. Julie was pretty, flirtatious, and enjoyed men, but Kathryn was sure Julie would be molested. She found herself rejecting Julie--denying the parts of herself she saw in her daughter..."As I rejected her," Kathryn said, "I was pushing her to get affection from someone else." Kathryn's shell began to crack when she recognized she was watching her own

history being repeated. This ultimately led her to a suicide attempt a year ago.

After hospitalization and therapy Kathryn is losing her toughness. "I've been walking around dead all these years," she says. "I want to be strong inside. I want to help my children."

She is beginning to enjoy life and accept her own past. She finally told her family about the incest. Some believed her; others said it was her fault. Kathryn knows other Native women who were incest victims in their villages. She says there are some strict taboos in her culture that prevent children from telling about the incest. Although sex with family members is not acceptable, there is a strong injunction against talking openly about sexual matters. In addition, family pride demands that nothing damage the family name, so children are bound to keep the sexual abuse quiet.

"We must tell the children they have a choice. No one should have to go through what I've been through."

Children do have choices as to who can use their bodies. Armed with proper knowledge, a healthy caution, and an assertive use of the word "no" they can choose to tell someone of the abuse and to stop it. Adults have not only the choice, but the responsibility to protect children from abuse in several ways.

The Justices in The Broken Taboo offer some guidelines for parents in establishing appropriate sexual boundaries with their children.

Be aware that parents and children normally have sexual feelings for each other at times, but it is up to the parent to prevent action upon those feelings.

* Don't sleep with your child. An occasional snuggling in bed in the morning is all right, but a regular pattern of sleeping with your child, especially as he or she gets to pre-school age, is too sexual.

* Be aware that wrestling and other sorts of play involving body contact may be sexually stimulating to yourself and your child.

* Don't use your child as a substitute for your spouse. If you are a single parent, avoid making the child the "little man" or "little woman" of the house. If you have a problem with your mate, avoid discussing it with your child.

* If you have stopped having sex with your spouse, or your marital relationship is floundering, seek counseling. If you are single, seek appropriate means of meeting your sexual needs.

* Encourage your child to express his or her feelings to you. Don't say," You shouldn't feel that way" if your child has painful feelings. This cuts down her or his ability to communicate with you.

* Give a child plenty of physical affection, but do not use physical closeness as a ploy to be sexual. It violates a child's trust in the people most important to him or her.

In The Silent Children, Stanford proposes that we give children the means of protecting themselves sexually along with the rest of the survival information we give them, such as "Look both ways before you cross the street," "Use your umbrella when it rains," and "Give the policeman your name and address if you are lost."

Begin early with simple information about sex. There are many good books available that can be read to young pre-schoolers and older children for those too timid or lacking in vocabulary to provide the information spontaneously. Appropriate words should be used for body parts, and children's sexual questions should be answered simply and honestly.

* Explain to your child that her body is private and that she does not have to be touched by anyone she does not want to touch her. This includes Grandma, who may give sloppy kisses and be repulsive to the youngster. Your child should be especially aware that her genitals are private, and that if anyone should touch them without her permission she should tell you or another adult she can talk to.

Tell your child specifically that no adult should be touching her genitals, even if the grown-up says it is okay. Tell her that you will protect her from harm if someone threatens her in order to keep the abuse secret.

Tell her that there are adults who harm children that they may be strangers or someone she knows, who harm children physically or use them for their own pleasure.

Repeat all the above messages as your child's age and sophistication increases.

* Most importantly, take the time to form a relationship with your child in which she can talk to you about things which are important to her.

Health care workers with a suspicion or direct knowledge that incest is a problem for their client should consult with the Department of Family and Youth Services for further advice. Incest must be reported.

PRINCIPLES FOR HELPING VICTIMS OF SPOUSE ABUSE

Violence and abuse are not appropriate in intimate and/or family relationships. It is not "deserved" or enjoyed by the victim. The abuser and the victims are not necessarily sick or crazy. Battering is a social problem and it is a learned behavior. A helper needs to assume that the battered or abused woman is potentially healthy and able to take care of herself and her family. Declare to both victim and abuser that the violence is the responsibility of the abuser. He must learn to change it--it is not her fault that he is violent. She can only change her own behavior and cannot cause or eliminate his violence.

If an abused person calls, assess the kind of violence and the extent of the danger that the victim faces. Both she and the abuser are very likely to minimize or deny the violence. This is even more pronounced in the longer or more violent relationships. Always take the reported violence seriously. Do not expect the victim to exaggerate or make up violence. She is more typically ashamed of it and can appear "numb" to the violence and pain she endures. Help her get a realistic picture of the danger, letting her know how to find shelter or safety when she needs it.

** CAUTION: You must be aware of your own attitudes/experiences with violence to avoid the common pitfalls of attempting to "rescue" the victim, or of reacting yourself. If you react with fear, the battered may interpret this as your inability to help her and the family, and her own sense of helplessness could be affirmed.

Emphasize her value as a human being who deserves not to be beaten. Let her know that you and others will help her but that there are no quick, easy answers. Encourage her to identify her fears in seeking your help. Make clear that you will keep information confidential and will not contact the

abuser. This is critical for women who are afraid of an abuser who has come to seem "omnipotent." The client may also fear that you will try to tell her what to do, i.e., leave her husband/spouse/lover, or that you will make moral judgements. Battered women often falsely believe that they deserve the abuse and do not deserve help. Let the client know that you believe her story and care what happens to her.

Allow her to tell her story without disbelief, interruption, or immediate pressure to begin problem-solving. The history of the relationship contains valuable information she will need in order to make changes, and to understand herself and her situation. She needs to recall, in detail, the extent of the violence, how she feels about it physically and emotionally, how others have reacted to the knowledge of it. Problems or issues in her own behavior, such as her own use of violence, can emerge. Help her sort these out from the problems and behaviors of her spouse, children or others.

Help her identify her feelings during or after the storytelling. This may be difficult for her since a common coping mechanism for battered women is the kind of numbness or helplessness that may camouflage anger and other strong emotions she has been unable to face in a violent relationship. Do not deny any of her feelings, i.e., anger at men or the abuser, feelings of love for him, etc. Help her express and label all feelings.

Identify how violence has changed or affected her behavior. Women with children often begin this process by talking about the effect of the violence on their children. This is sometimes the motivation for change. Work through this until she identifies the ways in which <u>she</u> has adapted to the violence and tried to protect herself to "prevent" the violence. Identify the behaviors and substances, such as tranquilizers, alcohol or other drugs which she may use to help camouflage the pain.

Self-esteem, self-care, and self-nurturance are necessary for the transition from a victim posture. Help her identify her strengths as well as her weaknesses. Do not encourage a constant focus on her victimization. Encourage her to state some positive roles for herself and dependent children. Clarify the need to change as more than a reaction to the abuse. (As long as all her actions are reactions, he continues to be in control.) Help her find activities and methods of making herself feel good and stress that this is essential to her well-being. Women are not usually socialized to find such resources, so the process may be slow to develop. Be very aware of the ethnic/cultural values in this process. Encourage the client to express these values as a source of self-esteem. Remember that religious beliefs can help, too.

Problem-solving begins with creating an achievable program. Develop a list of problems, establishing small steps to overcoming each one. The battered woman must learn and perform every step of this process herself. You can clarify the process and support the client, but resist every opportunity to do too much for her. Many times it seems faster and easier for the helper to get something done, but then the information and skill is not acquired by the client. It is helpful to identify the outcome, reward, or natural consequence of each step's achievement. For many victims of battering, a sense of consequences has been destroyed by senseless violence that distorts reality.

Advocacy with systems such as welfare, police, courts, schools and medical agencies, is also needed by many women in crisis or transition from violence. Again, as with problem-solving, the goal is to <u>teach</u> the method of getting help, and not to do the "leg work" yourself.

Keep the door open. Let her know that whatever she decides to do about her violent relationship is her decision and that you will not judge her if she tries again to cope with it. Express concern for her and her safety and the value you see in her. Many battered women return to the violence a number of times before they decide change is possible and that they don't want to live with it. Helpers who judge battered women and invest themselves in a "successful" outcome with the client ending the relationship will only increase her guilt and sense of unworthiness. She will not usually return to such a helper the next time she is ready to explore changing the situation.

Throughout your helping relationship with a battered woman make certain that you are not fostering dependency on yourself as a replacement for the abuser. Make sure that you have not taken over the victim's decision making. Get the personal support you need as a helper from resources in your own life. Make sure that you do not contribute to her customary burden of taking care of everyone else's feelings but her own.

SEXUALLY ORIENTED PROBLEMS

I. Introduction

Sexually troubled clients may have effects on us different from other clients. Sex is a highly charged area. It is easy to become so fascinated or put off by sexual behaviors that it becomes difficult to hear the person behind it. This in part explains why so often with these kinds of clients we jump to "do something," make quick referrals, or in some way react differently than we might with other clients.

We may also have unclear or unrealistic expectations of ourselves as staff. Some of these people are not asking for help to change. Some do not wish to modify their sexual orientation but want help with other problems. The therapist may find it difficult to see beyond the sexual orientation to the other problems.

Staff may also make the mistake of imposing their own value systems on such clients. As one staff member put it: "We have a certain reaction to the sexually oriented problem, and <u>our reaction</u> becomes the problem." The following material is to stimulate an ongoing discussion so that our reaction will not be the problem, nor add to it.

II. Definitions

A working definition for the sexually oriented client is: a person whose <u>primary</u> problem is uncomfortable sexual relationships caused or expressed through undesirable sex practices.

Clients having difficulty with sexual relationships brought on by loss or impending loss of a sexual partner are seldom primarily sexually oriented. As an example, a 42 year old man going through divorce is probably not a sexually oriented client. His sexual problem

(fear of loss of consortium) is secondary to other problems. The sexually oriented client, on the other hand, is one whose sexual practice makes it difficult to achieve satisfying sexual relationships even if other areas of his/her life are "normal." The following section describes various kinds of sexual behaviors which may be troublesome for particular clients.

A. Homosexuality/lesbianism

Sexually and erotically attracted to members of the same sex. Does include people who, although not presently engaging in same-sex sex, are attracted to the same sex.

B. Bisexualism

Persons who have sex with members of both sexes, sometimes concurrently, sometimes sequentially. Street language for bisexuals is AC/DC or switch-hitters.

C. Transvestism

Almost exclusively male, sexual pleasure is obtained by dressing in women's clothes, either instead of or during sexual activity. Dressing may extend from undergarments worn beneath normal clothing in normal situations to full women's dress, including undergarments, over garments, shoes, hose, and wigs. The sexual activity is masturbatory or heterosexual, but the wearing of female apparel is essential for sexual gratification.

D. Pedophilia

Usually an adult male who wishes to have sex with children who have not reached puberty. The sex attempted may be genital, but more frequently the child manually or orally provides genital sex for the adult.

E. Voyeurism

Usually males who watch females in various stages of undress. Permitted voyeurism includes go-go girl watching, watching burlesque strippers, and depending upon current fashions, "girl" watching in general. Forbidden voyeurism is peeping tom-ism.

F. Exhibitionism

Generally, the male exposes his genitals to a female in public, in an effort to upset the woman. This happens in libraries, parks, and other public places. It is more characteristic of older men than younger males.

G. Nymphomania

Women who engage in very frequent, indiscriminate sexual activity, generally with members of the opposite sex but occasionally with members of both sexes. True nymphomania is very rare.

H. Fetishism

Obtaining major sexual gratification from an object rather than a person. Objects generally are articles of clothing, and most fetishists are men; however any object may be a fetish--whips, chains, silk ropes etc. Sexual gratification is obtained by masturbating into or with the object, or having a sex partner wear the object. The object is the focus of sexual energy, not another person.

I. The Sexually Provocative Caller

Generally termed the "obscene caller," this person may differ from other sexually oriented callers in being provocative and aggressive. You may be propositioned, sworn at, or subjected to

provocative sexual language. (This is not a cry for help to which we can respond to effectively.) Both men and women make sexually provocative calls.

J. The Masturbating Caller

This caller--usually male--may or may not be a transvestite. He most closely resembles a fetishist, and a stranger's voice is the sexually charged "object." The dynamics are similar to the fetishist, since something is substituted for a real sexual partner. (The first call by a masturbator is the most important. Thereafter, either he/she is being directed to help or you are being used, and the latter is of no help to the caller.)

K. Incest

Sexual activity between family members. Is now known to be prevalent. Generally involves fathers and daughters. Rarely is sexual activity between mothers and sons reported.

III. Guidelines for Working with Sexually Oriented Clients.

A. For Homosexuality, Lesbianism, and Masturbation Disturbances, see special section later in text.

B. Bisexualism

Such a client usually seeks help because of a <u>loss</u> or change in a relationship. The loss may be actual loss of partner or loss of concealment of the bisexuality. Essentially, the bisexual male will use the heterosexual relationship to conceal a homosexual relationship. Loss of either is serious. Explore the meaning of the loss to the individual.

C. Transvestism

The transvestite caller presents special problems. He may appeal for just "talking," with no request for change. He may in some way use a female telephone respondent as a replacement for a sexual partner. The core problem of the transvestite is that sexual gratification is achieved through being dressed in women's clothing, not through a heterosexual relationship. The helping attitude can be one of accepting the person and at the same time having full recognition that some therapy is going to be necessary for the problem.

D. Pedophilia

Men with this problem feel sexually inadequate; they fear dominating, controlling women; and are angry and suspicious. With this type of problem, understanding and empathy are very important. A warm, accepting relationship is needed to encourage the caller to fully describe and discuss his problem and to feel that he may talk it over in detail with someone in a therapeutic relationship. In effect, if the male who fears mature women can be helped to overcome his fear through talking to an understanding and mature woman, it will help open the door to professional counseling.

E. Voyeurism

As with some other of these problems, the question is one of the age of the client and the extent of the practice. A 14 year old boy who spies on a neighbor college student who "just happens" to leave the window shade up is not the same as a 40 year old accountant who spends every night cruising the city for a good "peep." The former is acceptable and engaging in a universal practice; the latter has a problem.

F. Exhibitionism

Such individuals rarely call a crisis line. If someone does appear with this problem, refer them to a professional.

G. Nymphomania

The woman who compulsively copulates is unable to develop sustained relationships. When sex is no longer able to provide reassurance about her worth, she is in trouble. Compulsive sexual activity is a relationship problem. Self esteem is sought only in sexual terms, seeking the answer to the question, "How worthwhile am I"? Explore the meaning of the relationships, rather than spending time going over the frequency or other statistics of the sexual activity. Also explore how such a person sees her future. Focus especially on the problem for which she is now seeking help. Prodigious or unusual sexual activity can sometimes obscure other more basic problems having to do with relationships.

H. Fetishism

This client may present a problem to test the volunteer's reaction before going on. For example he might say: "What do you think of someone who collects women's shoes?" A flip response will turn the caller off. As always, leading questions such as the above are to test the helper's sensitivity. The hidden question really is, "Do you have any idea what I'd really like to talk about, and can I trust you?"

I. Sexually Provocative Client

The client whose purpose is to frighten or shock you will be reinforced, not helped, if you act frightened or shocked. So don't. You can remain calm if you understand this person is afraid,

depressed, and anxious.

Women may also behave in a sexually provocative manner, being seductive in relation to male volunteers. Males may be especially vulnerable to this kind of manipulation because it is unexpected and flattering. As with the male sexually provocative client, the female employs sexually charged language for purposes of manipulation. Her end goal is <u>control</u> of the male, not sexual liaison. Since women are seldom outright abusive, and not as explicit as men, and since males are less "threatened" by such clients, quick termination is seldom employed. Rather, the talk becomes complicated, confusing, and baffling, in the sense that no real goal is ever reached, but the talk continues. Differentiate <u>content</u> from <u>intent</u>. The content may be flattering, appealing, and stimulating. The intent is not. If you are a male volunteer in such a situation and if the female reports few successful male relationships, ask whether she relates to others as she is relating to you. Candid and open expression by you as to the effect of the client's seductiveness generally de-charges the emotional tone and you can get on to the basic issues. However, to do this effectively, the worker has to be sincere in rejecting the flattery.

J. Incest

Often the call will come from a mother concerned about her husband's interest in a daughter. Find out how explicit the interest has become. Ogling is different from explicit contact. Suggest she discuss this frankly with the husband, without the children around. If physical contact has been or is occurring, suggest again talking directly with her husband and also inform her

of community resources to intercede on behalf of the children.

K. The "Rapist"

Any client claiming the urge to rape someone should be taken seriously. Referral to a professional is in order.

IV. Conclusions

While the above may provide a better understanding of the language, definitions and dynamics of sexually oriented clients, and some broad suggestions, helping such clients that depends on your own views and your spontaneous responses. Your own feelings must guide you. They remain your most authentic and basic tool for helping. It is clear, however, that feelings need education, awareness, and skillful use.

This is why it is important to record your own reactions in the case records and to discuss them with your supervisor. If unexamined or ignored, perplexing feelings tend to get more perplexing.

No one has the corner on the "perfect" way to help these individuals. Once you get past the minimum suggestions, your own creativity and personal style count most. Question, record and discuss. This is the way to become a more successful, and skilled helper.

THOUGHTS ON HOMOSEXUALITY AND LESBIANISM

The only thing that makes homosexuals and lesbians different from heterosexuals is that they feel more strongly attracted to persons of the same sex. Since this attraction is probably the only thing that gay persons have in common, it's difficult to make general statements about them. In fact, most generalizations point out the prejudices and judgemental attitude of the observer(s).

Common Misconceptions

FALLACY: "I don't need to know anything about homosexuals and lesbians as I never come in contact with gay persons."

FACT: One person in every 20 (men and women) is more or less exclusively homosexual in orientation (Kinsey Report 1948 and 1953), and chances are that there is at least one gay person in any group of 7 or 8 persons.

FALLACY: "All gay persons have mannerisms and other characteristics that set them apart."

FACT: Only a few gay persons fit the stereotypes. In fact, stereotypes hold for very few persons straight or gay.

FALLACY: "Homosexuals molest children."

FACT: A survey of convictions for sex offenses involving juveniles in New Jersey, revealed that more than four-fifths of these cases involved heterosexual contacts (primarily men with girls). By far the largest fraction of incidents of sexual abuse of children occurs at home: fathers and uncles molesting daughters and nieces. Child molesting seems to be a male activity. Straight or lesbian women almost never molest children sexually.

FALLACY: "It is dangerous to talk about homosexuality particularly in front of children."

FACT: No one has been "made" gay by merely talking about it. Our bodies make sure that we learn about sex sooner or later. We also eventually discover whom we're attracted to and don't usually change very much. Some persons, both straight and gay, may choose not to act according to their orientation if there is strong enough pressure not to. However, no matter what we do, our sexual orientation is not likely to change.

"COMING -OUT" is the time when the individual makes the decision to declare themselves gay. Coming-out happens differently for everyone with family, in a support group, with a lover, after the birth of a child.

The decision to become a homosexual or lesbian is different from the realization that one is a homosexual. The realization comes first, no matter how painful. Then a decision needs to be made about whether to become part of the lifestyle/sub-culture.

There is an inner conflict that gays may be subject to. (Although not all gays are troubled by this.) The conflict is the discrepancy between one's chosen lifestyle and how one is raised by their parents. Parents do not raise their children to be gay.

Coming-out is a very difficult process. People should respect this unique process, as it is often a time when people are in pain and in their confusion hate themselves, and the "small" suicides start happening: booze, pills, isolation, prostitution, getting married, moving, etc.

The following questions may help the heterosexual worker deal with some of their feelings towards homosexuality.

1. What is the first thought that comes to mind when you think of gays?
2. Imagine telling your parents or friends that you are gay.
3. What is your first reaction upon seeing two men or two women walking hand in hand?
4. What is your belief about why people are gay or lesbian?
5. How would you feel if your mother, father, or child "came-out?"
6. Would you vote for a gay or lesbian school committee member, government representative, etc.?
7. Can you imagine wearing an "I am gay" button on your shirt for a day at work, etc.?

8. What have you always wanted to ask a gay or lesbian person?

SOME THOUGHTS ON DISCUSSING MASTURBATION AND OTHER SEXUAL ISSUES

1. Most people masturbate.
2. One of the basic services we have to offer is acceptance of a person as he/she is. Workers are not here to impose their own values on clients, or to make them feel bad about themselves and their lives because they are not using the worker's personal formula for happiness. Masturbating may be an appropriate expression of a particular person's sexuality at a particular time.
3. The service a crisis line offers is <u>someone to talk to</u> for people who are in a crisis situation.
4. Chronic excessive masturbation may be an expression of loneliness or depression. The individual may feel guilty, ashamed, inadequate, worthless, insecure, shy, anxious, ignorant, frustrated, frightened of women, or men. They may be very young, naive, physically disfigured or handicapped. They may have penis problems (size, impotence, premature ejaculation), or have difficulty forming relationships with women or men for any variety of reasons.
5. Some may be able to benefit from talking and it may be worthwhile to try to get past the sexual issue and create a relationship of acceptance and support. It may be the first time the individual has been able to talk freely about sex to a woman or man who did not reject, ridicule, punish, or act shocked toward them. This acceptance by another human being can be a step toward self-acceptance, self-confidence and perhaps a less limited life.

6. Avoid teasing, flirting, supplying details of your personal experiences.

7. Tone of voice is very important (as always). It is pretty hard to disguise it if you feel ill at ease, disapproving, nervous, or disgusted. It is better to be honest about how you feel and what you are here for, and to acknowledge your limitations in the situation.

8. Some who raise sexual issues are sadistic, hostile toward women or men, and get pleasure from having power over you by trying to turn you on, disgust you, or control your responses.

9. Don't waste time and resources on people who want something other than what crisis line workers are offering. You can generally tell within 5 to 15 minutes whether it is worth continuing the conversation. Trust your feeling. The success rate is generally low on helping people who enter with primary sex problems and do not want help.

RAPE

Rape is a violent crime which often goes unreported because of society's attitudes which are shaped by widely accepted myths about rape. Some of these myths are listed below, along with facts which refute the myths.

Myth and Fact Sheet

MYTH: Rape is a sex crime/ a "crime of passion."

FACT: Rape is not an act of sexual expression. Rape is an act of power and domination, of anger and hostility towards another person. Sex is used as the vehicle or weapon to act out these feelings.

MYTH: Rape is an impulsive, uncontrollable act of sexual gratification; most rapes are spontaneous.

FACT: Most rapes are planned (the place, if not the person).

MYTH: Rapists are insane, "abnormal" or perverted, sexually deprived and frustrated, or "over-sexed."

FACT: Rapists tend to exhibit "normal" types of behavior, with the exception of a greater than average tendency toward expression of violence. Most rapists have consenting sexual relationships in their lives at the time of the assault on the rape victim.

MYTH: Only young, attractive women are raped.

FACT: Anyone can be raped. Men, as well as women, young and old become victims of sexual assault (from infants to elderly persons).

MYTH: Most rapists are strangers to the victim.

FACT: The majority of rapes are committed by a person a known to the victim.
(This is especially true in small rural communities.)

MYTH: Rapes happen in secluded places, such as dark alleys and empty parking lots.

FACT: Rapes happen anywhere and at anytime; 35% and up occur in the victim's home.

MYTH: Women frequently cry "rape" (i.e., there is a high rate of false reporting).

FACT: Studies show that only 2% of rape calls are false reporting.

MYTH: Women fantasize about being raped.

FACT: Women may fantasize about being romantically involved or even "seduced," but they rarely fantasize about being raped.

MYTH: Rape victims "ask for it."

FACT: Rape victims are in no way responsible for the actions of the rapist. Nothing a woman says or does justifies rape.

MYTH: Most rapes are interracial.

FACT: Nationally, FBI statistics show 3% of rapes involve black men and white women; 4% white men and black women. Most rapes involve a rapist and a victim of the same race. In Alaska, however, a significant percentage of rape victims are Native women, accounting for up to 40% of "known" statistics. Their assailants are, in order of decreasing prevalence, white, black, Hispanic/other, and Native men.

MYTH: Rape only occurs in large cities.

FACT: Although the reported number of assaults is higher in urban areas, sexual assault also happens in rural areas, including the villages.

General Types of Attack

1. Surprise Attack The victim is leading her usual everyday life and a moment later she is attacked. She feels her world is shattered.

2. Marked Victim The victim knows or has met her assailant prior to the assault. She feels she has no reason to fear him. He assaults her, she feels betrayed. Some victims feel guilty because of their trust or vulnerability.

3. Initial Consent to Sex Often called false reports by the police. These are cases in which a woman initially agreed to have relations but something went wrong (the male became violent or perverted, the woman became anxious or changed her mind, but the male persisted).

Post-Rape Reactions

After a woman has been raped her primary feeling may be fear. It is normal for her to be afraid of crowds, of men, of anything reminding her of the assailant, of having her mate or friends find out about the incident.

In addition to being afraid, a rape victim may feel embarrassed, guilty, suspicious, and/or angry. She may become obsessed with the assault, and her normal sex life may be disrupted.

When a rape victim presents to you, she may have trouble talking, she may be hyperverbal, she may cry or be silent. Sometimes she may claim to be a friend of the victim.

Concerns of the Victim

1. Whether to report it
2. VD and pregnancy
3. Fear of assailant's return
4. Need to ventilate anger
5. Fear of being alone
6. Concern about legal procedures
7. Fear of friends finding out
8. Need to discuss feelings

How to Handle Rape Victims

1. Listening and indicating that you understand are important to the victim. By trying to share her feelings at the moment she is, in essence, helping herself.

2. During the impact period the victim is sensitive to any action or statement you make and often fears pressure from you even when she seeks advice.
3. Even if the woman says she is a friend of the victim, keep in mind that she might be the victim herself. She may not be able to admit it at first.
4. For the victim who has trouble communicating, the listener can begin with an open-ended question or statement "Why don't you tell me all about it?"
5. Assure the victim that she has not been singled out for an attack. This happens to thousands of women, and it is not their fault.
6. Try to phrase questions in a manner that won't inhibit the victim. Ask, for example, "Do you have any physical concerns right now?" This will leave the door open for her to explain injuries, fear of pregnancy or VD at her own rate as she wishes.
7. It sometimes helps the victim if you tell her that this incident <u>will</u> disrupt her life for a while, that it's natural to feel traumatized after being attacked.
8. If she feels guilty because she didn't fight, you can assure her that fear inhibits most people and that survival is the most important thing.
9. Refer to rape crisis experts is usually indicated unless such services are unavailable.

HANDLING CASES

The following are some illustrations of what may be considered typical problems. A description is given of the individual and the problem presented and suggestions are made for handling the situation. It should be remembered that these are examples which have been generalized for teaching purposes and that people do not fall exactly within these given descriptions.

1. A woman, between 30 and 40 years old presents at night saying that she doesn't understand why she feels so depressed. She states she is alone, complains of not being able to sleep, of having troubled thoughts, and says that she really doesn't want to kill herself but she has had suicidal thoughts over many months or even years. She may be agitated, depressed, or weeping, as if she is having a hysterical breakdown. She may be demanding and ask what can be done to help her right now because she feels she is not able to get through the night. Questioning will reveal she has had many similar episodes. It is probable that she is reacting to some interpersonal conflict such as an argument with a family member or a close friend. There is no history of suicidal gesture or action.

Since in this case there is suicidal ideation without intent to act and with no history of suicidal gestures or actions, the worker is reasonably safe in assuming there is no immediate danger to the patient. It is best to listen patiently and wait for the opportunity to point out realistically that things look worse at night, and that it is not the best time to get help. She should be advised to call her doctor or social work agency or clinic in the morning to arrange a program of help. It may be helpful to suggest that she call a close friend or relative to come and be with her during this difficult night.

2. A man between 20 and 30 sounds evasive and anxious and is reluctant to give information. He talks about having a problem which he is hesitant to identify, and states he is looking for help because the only solution he can think of is to kill himself. His suicide plan will be an impulsive one, like smashing his car up or cutting himself with a razor blade. Frequently such a man has a personal problem about which he feels guilty.

This patient should be encouraged to seek help. He should be commended for having done the right thing in calling as a beginning effort to get help for himself. You might suggest other resources such as a psychiatric clinic, private therapist, physician, school counselor, or continued work with yourself if you feel qualified.

3. The caller is a neighbor or friend and is concerned about someone he knows. He may be reluctant to assume any responsibility, but requests that you do something about the person he is concerned about. He is not able to give you too much detail or information about the situation which concerns him.

You should get as much information as you can and encourage him to let the person know that he is concerned. Ask him to advise the patient to call you. You should point out that it would be unrealistic for you simply to call someone without being able to say who notified you. The caller should be told that it is his responsibility to be involved if he is really concerned about a person who is suicidal.

The Hostile or Aggressive Client

The hostile patient can be particularly upsetting to a new worker. The client is angry and abusive and the worker is on the receiving end of all his

hostility. There is a natural tendency to become defensive and to try to explain away their angry comments, or to react with anger yourself. Your response can contribute to such hostility as the client may conclude: "Everybody is mean, even you!" So try not to get hostile, too.

One method of dissipating or getting past such anger is to let the patient know you understand their feelings. Try to help them find a more rational way of dealing with problems. Don't challenge. Allow the client to defeat you by refusing to fight, and then they will usually be more open to talking about their feelings.

Don't try to work with all their problems at once. Remember, they generally have a low coping ability and dragging up all of their problems at one time is liable to make them even more anxious and unable to cope. Focus on specific problems where some progress can be achieved. Even a little progress is an achievement.

Co-ordinate your work with that of the other workers. Be concrete and down to earth. Respect the anger of this individual as the anger itself can be a teacher to both that individual and yourself. Anger, like any painful emotion, if controlled and properly utilized, can serve the client by helping define the problem and possibly the solution. (See Section on Healthy Fight and Anger Management.) If anger is managed properly, it can be turned into a constructive asset which creates self knowledge (insight about who you are and what you need) as opposed to a destructive force or problem creator.

Handling Manipulative Callers

You will experience clients who will try to manipulate you. These people will ask for (or otherwise attempt to get you to give them) something you are unwilling or unable to give. Manipulative people may try to get you to:

1. tell them what to do (give advice/make their decisions)

2. help them avoid the real problem

3. help them harm themselves

4. participate in or help them accomplish illegal acts

They try to get you to do these things by:

1. asking you directly

2. being indecisive

3. making excuses ("yes, but...")

4. talking about issues not relevant to the stated problem

5. pretending to have one problem but really having another

6. talking about no problem at all

7. depreciating themselves

8. criticizing the worker

9. playing one worker against another

Most callers who manipulate the worker do not realize they are doing so. They may not know your rules. They may not understand that you take a non-judgmental approach and do not advocate giving advice when it would lead to taking the ownership of the problem away from the caller. Sometimes callers are unaware of the real problem causing their discomfort. They only know they are feeling uncomfortable and want to get rid of the bad feelings in the fastest possible way.

Here are some specific examples of clients asking you to do something you do not want to do or are not able to do.

1. A man asks you to describe in detail what you like to do in bed so he can masturbate.

2. A woman contemplating divorce wants you to tell her whether to file now or wait to see if things get any better.

3. High school student asks you to tell her where she can buy some marijuana.

4. You have talked with a client about chronic depression several times over a month's time. Each time you talk to this person he decides to go back to his mental health worker. He never follows through yet continues to ask you to help him solve his problem.
5. You have talked with a client about her loneliness for 45 minutes. She has an excuse for not trying every alternative you've suggested but still insists that she needs help with her problem.
6. A woman initially states that she has a marital problem but spends a large portion of the time talking about past events that have little or no relation to the stated problem.

Recognizing Manipulation

As you try to help a manipulative caller by reflecting their feelings and problem and by trying to engage them in problem-solving, you will probably begin to experience in yourself feelings of being frustrated, disappointed, helpless, guilty, confused, or angry. The fact that you are having these feelings about a client is one good indication that the client is expecting something that you can't or won't do. Recognizing manipulation is often a matter of listening to your own feelings about the patient and defining what he is doing that makes you feel this way.

Circumstances other than manipulative behavior from a caller can cause these feelings in you, such as:

1. Client's problem bothers you because you have experienced a similar problem or feeling yourself.
2. Client has a problem which you feel uncomfortable talking about (sex, drugs, religion, etc.)
3. You are not feeling well, emotionally or physically.

4. It sounds like a "heavy" talk and you just finished an emotionally draining call.

5. You recognize you have been unsuccessful in the past with a client.

The only way to know that a client is manipulating you is to determine what the person is asking you to do that you are unable or unwilling to do. Refer to the previous examples.

In example #1 the client wants you to help him get sexually aroused by talking about your sexual preferences. You will not do this because you do not want to be used sexually in a session.

In #2 the client wants you to tell her what to do. You will not do this because she owns the problem and ultimately has to live with the decision.

In #3 the client wants you to help her buy drugs. You will not do this because it is unethical for you to help someone commit an illegal act.

In #4 the client wants you to help him deal with his depression. You are unable to do this because he has never followed up on his decision.

In #5 the client wants you to help her with her problem of loneliness. You cannot do this because she has rejected every alternative you can think of.

In #6 the client wants you to help solve a marital problem. You cannot do this because she has not fully described her problem to you.

Handling The Client

There are four questions you must ask yourself when you begin to feel that you are being manipulated.

1. What is the client asking me to do that I will not or cannot do?
2. Why can't (won't) I do what the client is asking?
3. How do I feel about what is happening?
4. What can I do for the client?

Once you have decided what the client wants, why you can't give it, how you feel about it, and what you can give the client instead, you must tell the client this.

When you confront a manipulative client, the idea is to get them to stop manipulating you and start working more constructively on the problem, not to punish or hurt her/his feelings. To avoid being punitive, you must:

1. Not wait so long to confront that you become angry with the client. Confront as soon as you realize she/he is asking for something you can't give.
2. Express your feelings about being manipulated openly and without sarcasm. If you hint or hedge instead of openly stating what is happening or if you are sarcastic, he/she may misunderstand you and feel mistrustful.
3. Be sure you tell the client your limits to avoid giving an impression that you don't really want to help with the problem.
4. Send your feelings to the client in the form of an "I message" or a "you message."

Example of an "I message" - - I feel discouraged about helping you solve your problem because you've rejected every possible solution I can think of. The only way I can help you is to go over the alternatives again. Maybe we can think of some new ones.

Example of a "you message" - You aren't cooperating! Maybe I could help you if you'd consider any of the alternatives I've offered you. Now get busy and think about them again.

No matter how openly and non-threateningly you state your feelings to a manipulative client, she/he may still feel hurt, rejected, or angry. If a client reacts with anger and hostility to your message you should:

1. Be careful not to react defensively or angrily. Reflect the client's feelings of hostility. Make sure the client knows you have heard the discomfort she/he is feeling.
2. Restate what you can do so she/he knows you still want to help with the problem.
3. If the client is still angry or hurt, restate your original position in as non-threatening manner as possible. "I know you want me to talk about my sexual preferences but I'm not going to because I don't want to be used sexually. I can talk with you about your problem, refer you to a counselor, or talk with you later."

If all your efforts to get a manipulative caller to work constructively on the problem fail, you must accept the fact. You will not be able to help every client you listen to, and some clients are not ready to accept help. If you feel you have not been helpful, ask yourself:

1. What went wrong?
2. Could I have done something more?
3. Could the client have done something more to help her/himself?

If you are unsure about the answers to these questions, talk it over with your trainer, your shift partner, staff, or a friend. Get their ideas about how you might have handled the client differently. If no one can come up with

better ways of handling the situation, accept the fact that the individual wasn't ready to be helped.

Handling Requests For Personal Information

Callers may quiz you about yourself for several reasons:

1. They may want to know whether you can understand the problem. Such questions as, "How old are you"? "Do you have children"? may be subtle messages saying, "Can you identify with my problem enough to help?"
2. They may be turning the focus on you to avoid talking about the problem. In this case the questions are sending the message, "I'd rather talk about you than face my own problems."
3. They may want you to talk about your physical appearance or sexual preferences so they can become sexually excited.

Since it is difficult to know what message a client's questions are sending until you talk further, a good response to requests for personal information is:

> "I could answer some personal questions about myself, but I feel uncomfortable, since I don't know why you want to know about me."

After you have talked with the client for a while, they may tell you why they are asking questions about you, or you may discover the reasons during the course of the conversation. Look at the list of three reasons above. Here are appropriate responses for each reason.

1. It sounds like you're wondering whether I've had the kind of experiences I would need to help you with your problem.

2. You'd like to know some things about me, but you came here to talk about a problem. Could you tell me more about your situation?

3. I don't want to talk about myself because I don't want you to use the information to become sexually aroused.

Be honest with the callers. Don't ignore their questions face them squarely with whatever honest response seems appropriate.

Handling Panic

Telling hysterical, irrational clients to "calm down" doesn't usually help. Instead, you should indicate that you hear their distress and will try to help as soon as they can tell you what is wrong, even if you can only hear crying or other distress signals at the beginning. For example:

"May I help you?"

(hysterical crying)

"Something is upsetting you terribly. I'd like to help if I can. Can you tell me what is happening?"

(more crying)

"I really want to help, but I can't do anything until I know what's the matter."

"My husband...beat me."

Working With The Quiet Client

In the silent or quiet client we may have an excellent example of ambivalence. Here is a person who deliberately made the effort to call or come to a center designed to assist people who have personal problems. But when they reach the source of assistance, for any number of reasons they may choose not to engage in verbal communication which may be necessary to

alleviate the problems. This behavior, which appears inconsistent, usually has a basis in the client's psychological makeup or in previous experiences with helping agencies. Many callers to a suicide prevention center have been rejected by other agencies and organizations or by their families and friends and therefore are unsure whether or not they will be accepted and listened to at the suicide prevention center. As a result, they may call in a reluctant manner to reduce the psychological effect of the potential rejection.

To the quiet, shy client being accepted by the therapist is critically important but this intimate relationship with another individual may become too frightening. The impact of the closeness may frighten the client away from beginning a conversation unless the person on the other end is aware of this fear and does something to facilitate talking with a statement that says, "you can trust me," "I want to help," or I'm here to listen."

The worker must remember that their first task as a therapist is to meet the client at their level of acceptance and to try to remove any impediment which may keep the person from communicating a problem or difficulty.

Such a client expects anger, rejection, or hurt. By accepting their feelings and concerns, and exploring what kind of relationship is acceptable, the counseling center reinforces its role as an accepting therapeutic service.

Techniques For Handling The Quiet/Shy Client

1. Be concerned. The best listener is one who cares and is willing to get involved with another person. If you are motivated by true concern, you will be [illegible] other people and attentive to what they say. Even if what they say seems disjointed or confusing, remind yourself that there is no such thing as a worthless conversation. Your concern and attention are all that is generally required.

2. Be patient. Very often a person with serious problems has difficulty expressing her/or himself. You have to be willing to wait things out. It may take time, but giving time is giving everything. The other person will sense your giving spirit and respond to it. It may take more than one conversation, so it helps to leave the door open for a resumption of the talk. Patience means working on the other person's schedule, not your own.

3. Be accepting. This requires an open, non-judgemental stance towards the other person. Quite often the thing that's troubling the client is something morally questionable or even shocking. Yet the good listener must learn to be unshockable. Accept the person as they are. It is only at this point that a person can begin taking steps in another direction.

4. Be helpful. Not everyone can talk easily and clearly and logically. Sometimes it's necessary for a listener to get the conversation back on the track with a quiet question or sympathetic comment. Don't be too quick, though, to jump in with what seems the right phrase or right question. Silence is important too.

5. Be honest. It's important that you be honest with yourself and your own feelings, as well. Listening is not a passive thing; it's an active dialogue requiring honesty on both sides. If the listener is not true to his or her own feelings it's possible to be caught in the bind of becoming preoccupied with their own feelings. The only way to avoid this is to respond honestly in such a way that your responses are congruent with your own feelings.

6. Be faithful. A good listener is careful not to violate confidence. Some people find it very hard to refrain from passing along information given in confidence. This is unpardonable!! The listening relationship

is a sacred one which requires a pledge of absolute confidentiality. Be careful not to profane or misuse the trust which another person places in you. Qualifications to this are your obligation to report sexual abuse of a minor or impending danger to others.

GROUND RULES FOR A HEALTHY FIGHT

Fighting between people is frequently necessary in order to conduct and maintain stable human relations. If the following rules are followed, fighting can be done in a healthy way. This means problem solving without destructive activity.

1) LISTEN - DO NOT INTERRUPT: The purpose of the discussion is to communicate in order to listen, understand, respect, and then negotiate and compromise.

   In order to do this, there must be a certain degree of calm, for if the parties involved are too angry or upset they will not listen or understand. Instead, they will interrupt and only debate. It can be good to debate, but only debate and interrupting each other is very destructive. The goal is not domination and winning; rather, it is compromise and negotiation through caring and sharing.

2) PROBLEM IDENTIFICATION AND PROBLEM SOLVING: The problems existing between those involved should be identified and clearly stated with an eye towards solving those problems. Thus, the communication is goal directed. Do not stray off the subject; stay with one problem at a time. If you try to deal with more than one problem at a time, you will only get confused. You may not be able to solve the whole problem or even part of a problem at one sitting, if that problem is a long-term, particularly painful, complicated one. Therefore, do not be overwhelmed and discouraged if this failure of problem resolution should occur. Over time, many problems will be solved. Some problems can be solved rapidly with only a few short communications, and other problems will remain unresolved for a very

long time and maybe permanently. When this occurs acceptance becomes important.

3) ANGER: If you or your loved one is too angry or upset in any way to listen and negotiate, both of you should withdraw to neutral corners until relaxed and calm enough to be able to understand and compromise again. Signs of destructive anger, including verbal attacks, blaming, character assassination, name calling, cutting down, and dredging up the past, indicate the need for the fight to be terminated until the parties involved are relaxed again. Bringing up the past can be good and at times useful in figuring out and correcting mistakes, but can and is used as a weapon when anger is at the destructive level. It is possible, but very difficult, to use anger as an assertive tool to identify your and other's problems, but it must be done below a certain level, or else it becomes terribly destructive. So, obviously there is safe anger and destructive anger, and the line between the two is very thin. There should be no threats or shouting. You can be angry and show that you care at the same time so that love and anger go together; however, if too angry, then hate and destruction replace the love. Encourage, do not attack. Hitting, kicking, pounding, or any violence to property or person are absolutely out 100% of the time. Also poor is to hold anger in, as then it comes out in lies, stubbornness, refusal to recognize other's point of view, and other negative, passive-angry ways.

Therefore, the middle part in between being passive and being explosive is the right amount of anger, and in that middle level anger can be a useful tool.

4) BREVITY: Be brief, concise, looking to now and the future. Deal with the past only as a reference point for how to avoid repeating the same mistakes so that you can improve now and future. Do not bring up irrelevant or unrelated items to attack, win or avoid.

5) TIMING: There may be a need for a special time to have these problem-solving meetings or the meetings can occur as needed. Be very aware of proper timing as a way to avoid explosions. If one is exploding, do not fan the fire or put oil in it by provoking. Either help calm the person down or walk away.

6) RUNNING AWAY: Do not run away emotionally, physically or mentally unless you need a rest and time out, but do try to return when you have rested.

7) MISUNDERSTANDING: Message sent is often not message received. Restating in your own words frequently will help avoid this problem. People in some ways are very different in thought, feeling and action, so do not expect to understand and be understood easily without a lot of effort, time and pain.

8) THIRD PARTY: Do not communicate through a third party or a third system. Communicate directly to the person involved with your problem.

9) RESPONSIBILITY: Assume responsibility for your part in the problem. Apologize, if that seems necessary and indicated, and look for as many solutions as is necessary to solve those problems; then practice.

MENTAL HEALTH COMMITMENTS

(CIVIL COMMITMENTS)

WHAT IS A CIVIL COMMITMENT?

A civil commitment is a procedure through which a mentally ill person is placed in a hospital or other type of health care center for treatment of his or her mental illness.

WHAT IF A MENTALLY ILL PERSON DOESN'T WANT TREATMENT?

There are two types of commitments: voluntary and involuntary.

A mentally ill person may voluntarily admit themselves to a treatment facility by signing papers agreeing that they want to be admitted. A person who has been voluntarily committed can withdraw their consent at any time. If a person withdraws consent, they must be released unless an involuntary proceeding is started.

(At this point in time, Alaska Psychiatric Institute in Anchorage is the only treatment facility in Alaska designated by the Department of Health and Social Services to receive persons seeking to formally commit themselves on a voluntary commitment. However, a number of other hospitals will also admit persons who seek to enter the hospitals because they are mentally ill.)

If a mentally ill person does not want to get treatment, or if they are so ill that it is impossible for them to determine what they want, the superior court can commit the individual for treatment against their will under certain special circumstances which are described in the Alaska Statutes.

HOW SICK DOES THE MENTALLY ILL PERSON HAVE TO BE BEFORE THEY CAN BE INVOLUNTARILY COMMITTED?

Alaska law is clear on this point. The person must be mentally ill and, as a result of the mental illness, must be GRAVELY DISABLED OR PRESENT A LIKELIHOOD OF SERIOUS HARM TO HER/OR HIMSELF OR OTHERS. (Gravely disabled means that the person cannot take care of their own basic needs, like food and shelter, and this inability puts them in danger of serious harm.)

WHO MAKES THE DECISION ABOUT WHETHER OR NOT SOMEONE SHOULD BE INVOLUNTARILY COMMITTED?

A superior court judge will decide whether or not a mentally ill person will be involuntarily committed after the judge hears the facts of the case and the opinions of mental health professionals (for example, psychiatrists) who have examined the mentally ill person.

HOW DOES THE INVOLUNTARY COMMITMENT PROCEDURE START?

The procedure usually starts in one of two ways.

1. Any adult can file a petition with the superior court (not a district court judge or magistrate). A petition is a legal document which says:
   a. that the petitioner (the person who makes out the petition) believes the mentally ill person (called the respondent) is likely to seriously harm her/or himself or others, or is gravely disabled as a result of mental illness.
   b. the facts which support the petitioner's belief, and

c. the names and addresses of all persons known to the petitioner who have knowledge of the facts through personal observation.

When a superior court judge receives a petition, he or she immediately takes steps to direct a mental health professional to do a screening investigation of the mentally ill person. Depending on the results of that investigation, either the mentally ill person will be hospitalized and a court hearing will then be scheduled, or no further action will be taken.

2. If a peace officer (for example, a state trooper or a policeman) has good reason to believe THAT A PERSON IS GRAVELY DISABLED OR IS SUFFERING FROM MENTAL ILLNESS AND IS LIKELY TO CAUSE SERIOUS HARM TO HER/OR HIMSELF OR OTHERS OF SUCH IMMEDIATE NATURE THAT CONSIDERATIONS OF SAFETY DO NOT ALLOW FOR A PETITION TO BE FILED AND SCREENED AS DESCRIBED ABOVE, the peace officer can take immediate action. The peace officer can take the mentally ill person into custody and deliver them to the nearest hospital or other appropriate facility which can evaluate the person. (Government health officers and public health nurses are considered peace officers under this law, also.)

When the peace officer delivers the person to the evaluation facility, the peace officer fills out a request that the person be examined by a mental health professional. The person is admitted to the facility and held while an investigation is conducted. The investigation must take place within 24 hours of arrival. Depending on the results of that investigation, the mentally ill person may be hospitalized and a court hearing will then be scheduled.

WHAT CAN I DO IF I KNOW SOMEONE WHOM I THINK IS MENTALLY ILL AND NEEDS HELP? WHOM SHOULD I CONTACT?

You can get information about how you can help a mentally ill person by contacting your community mental health center or your regional mental health supervisor. A list of these agencies is provided at the back of this book.

If the situation is an emergency (for example, if you think the person is going to hurt self or others if some immediate action isn't taken), contact a peace officer. As described above, a peace officer can take immediate custody of the mentally ill person.

If the situation is not an emergency, you or any other adult can write up and sign a petition about the mentally ill person and give it to a superior court. (There is no filing fee or other charge for doing this.) Each superior court in the State has petition forms you can fill out and sign. The addresses of all superior courts are listed at the end of this book.

A person who files a petition in good faith upon either actual knowledge or reliable information cannot be found civilly or criminally liable as a result of filing the petition.

However, a person who willfully begins an involuntary commitment procedure by filing a petition with the superior court without good cause to believe the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to self or others is guilty of a felony.

This petition cannot be handled by a district court. It can only be handled by a superior court. IF YOU LIVE IN A COMMUNITY IN WHICH A MAGISTRATE IS THE ONLY JUDGE, THE MAGISTRATE CANNOT HANDLE THIS CASE FOR YOU.

WHAT IF YOU LIVE IN THE BUSH AND NO SUPERIOR COURT IS AVAILABLE?

In the event no superior court is readily available, there are a number of alternative methods that may be used to initiate the involuntary commitment process.

1. In an emergency situation, any peace officer may take the person into custody and deliver him or her to the nearest evaluation facility. This means that a local police officer, a state trooper, a village public safety officer, or other peace officers as defined in the law, may take custody of a mentally ill person in an emergency situation and transport that person (by airplane, boat, car, etc.) to the nearest community that has an evaluation facility and deliver the person for evaluation as previously described.
2. In a non-emergency situation, the local magistrate, community mental health center staff, or regional mental health supervisor will be able to either provide the necessary petition forms or otherwise assist in initiating the involuntary commitment process.

IF A PERSON IS COMMITTED, WHERE DOES HE OR SHE GO?

From the time any action is taken against a mentally ill person, that person is entitled to legal protection and help. The person has definite legal rights which will be protected.

The person has the right to be notified, orally and in writing, of the commitment proceedings and their rights.

These explanations must be given in language the person understands. (A minor has the right to communicate with a guardian or another adult of their choice.) He or she will be represented by a lawyer, and is entitled to a free lawyer if the family cannot pay a lawyer. The person in question will be able to attend court hearings about their case, and can present evidence and cross-examine witnesses. They have a right to have a court hearing within 72 hours (excluding weekends and holidays) after arrival at a treatment facility

for evaluation, and have the right to have further hearings 21 days later, then 90 days later and then 120 days later if they continue to be committed. They have specific rights to receive treatment and to refuse specific types of treatment which are listed in the Alaska Statutes, and freedoms can only be restricted to the extent necessary for the individual's treatment. They must be released at any time if their condition improves to the point that they are no longer committable. They retain their civil rights, and care and treatment are kept confidential. After release, the person can even request that all records of the commitment proceedings be expunged (erased).

HOW LONG IS A CIVIL COMMITMENT FOR?

That depends. A committed person must always be released as soon as their condition improves to the point that they can no longer be committed under the standards of the law.

If the person was taken to a treatment facility by a peace officer, the first court hearing must be held within 72 hours (excluding weekends and holidays) of when the mentally ill person arrived at a treatment facility for evaluation. If the superior court judge finds that the person should be committed, a 21 day commitment order is made. At the end of the 21 days, if the person's condition has not improved, another hearing is held and the person may be committed for up to 90 days more. Likewise, at the end of 90 days, another hearing may be held and a commitment order of up to 120 more days may be made. After that, hearings are held and orders are made every 120 days.

A voluntary commitment can last as long as the person continues to be mentally ill and continues to consent to a voluntary commitment.

CAN A CHILD BE CIVILLY COMMITTED?

Yes, but the procedures are slightly different. The child's parents or guardians are involved in the procedures. After age 14, a child may be voluntarily committed to a treatment facility in the same way an adult is.

CAN A PERSON APPEAL A JUDGE'S DECISION ORDERING A CIVIL COMMITMENT OF THAT PERSON?

Yes, the person can appeal from any court order of involuntary commitment, and the judge must tell the individual about their right to appeal.

WHO PAYS FOR ALL OF THIS?

To the extent that they are able, a person who is committed, or their legal guardian, spouse, or parents if the person is under 18 years of age, must pay for the care, transportation and treatment of the person. If no one else can pay these expenses, the State of Alaska will pay.

When the commitment process is started, the Department of Health and Social Services is required to arrange and pay for the transportation of the person to a treatment facility. The department also pays for appropriate persons to go with the mentally ill person, and for return transportation for these people. When advisable, one or more relatives or friends shall be permitted to go with the mentally ill person. The department may pay necessary travel, housing and meal expenses for one relative or friend to go with the person, if the department finds that the person's best interests require that they travel with the relative or friend and the relative or friend doesn't have enough money to pay their own expenses. For more information about this possibility, contact your community mental health center or your regional mental health supervisor.

SOUTHEAST REGIONAL PROGRAMS

Joseph Adelmeyer, ACSW
Regional Administrator
Southeastern Regional Office
Department of Health and Social Services
Division of Mental Health and DD
Pouch H-04
Juneau, AK 99811

Lynn Canal Mental Health Program
P.O. Box 117
Haines, AK 99827
766-2177

Cordova Community Hospital Mental Health Program
Box 160
Cordova, AK 99574
424-7131

Copper River Mental Health Center
Drawer "H"
Copper Center, AK 99573
822-5241

Kodiak Island Mental Health Center
Box 712
Kodiak, AK 99615
486-5742

Gateway Community Mental Health Center
3134 Tongass Avenue
Ketchikan, AK 99901
225-4135

Juneau Mental Health Clinic
529 Gold Street
Juneau, AK 99801
586-3580

Baranof Mental Health Clinic
Box 1180
Sitka, AK 99835
747-8994

Valdez Counseling Center
Box 1050
Valdez, AK 99686
835-2838

SOUTHCENTRAL REGIONAL PROGRAMS

R. Steven Harrison, Ph.D.
Regional Administrator
Southcentral Regional Office
Department of Health and Social Services
Division of Mental Health and DD
3601 C Street, Pouch 6333
Anchorage, AK 99502-0333

Anchorage Community Mental Health Center
3944 Spenard Road
Anchorage, AK 99503
243-5411

Mat-Su Community Counseling Center
Box 656
Wasilla, AK 99687
376-2411

Central Peninsula Mental Health Center
Box 4683
Kenai, AK 99611
283-7501

Unalaska Service Center
1689 C Street
Anchorage, AK 99501
276-2700

KNA Community Counseling Program
Box 155
Aniak, AK 99557
675-4445

South Peninsula Mental Health Center
Box 2274
Homer, AK 99603
235-7701

Yukon-Kuskokwim Health Corporation
Box 528
Bethel, AK 99559
543-3321

Mental Health Program
Box 1045
Seward, AK 99664
224-5215

Bristol Bay Mental Health Center
P. O. Box 10220
Dillingham, AK 99576
842-5256

NORTHERN REGIONAL PROGRAMS

Jack McCombs, MA
Regional Administrator
Northern Regional Office
Department of Health and Social Services
Division of Mental Health and DD
1919 Lathrop Street
Suite 200, Drawer 31
Fairbanks, AK 99701

Yukon-Tanana Mental Health Program
Box 149
Tanana, AK 99777
366-7269

Fort Yukon Behavioral Health Center
Box 21
Fort Yukon, AK 99740
662-2526

Norton Sound Family Services
Box 966
Nome, AK 99762
443-5206

North Slope Borough Mental Health Program
Box 669
Barrow, AK 99723
852-5600

McGrath-Anvik Community and Family Services
Box 44
McGrath, AK 99627
524-3867

Yukon-Koyukuk Mental Health Center
Box 17
Galena, AK 99741
656-1617

Maniilaq Mental Health
Box 256
Kotzebue, AK 99752
442-3313

Fairbanks Community Mental Health Center
209 Forty Mile Ave., Gruehl
Fairbanks, AK 99701
452-1575

Tok Area Mental Health Program
P.O. Box 398
Tok, AK 99780
883-4851

SUPERIOR COURT LOCATIONS

ANCHORAGE: 303 K Street, Anchorage, AK 99501 (264-0440)

BARROW: Box 270, Barrow, AK 99723 (852-4800)

BETHEL: Box 130, Bethel, AK 99559 (543-2196)

FAIRBANKS: 604 Barnette St., Rm. 342, Fairbanks, AK 99701 (452-1551)

JUNEAU: Pouch U, Juneau, AK 99811 (465-3456)

KENAI: Pouch I, Kenai, AK 99611 (283-3110)

KETCHIKAN: 415 Main St., Room 400, Ketchikan, AK 99901 (225-3195)

KODIAK: Box 1367, Kodiak, AK 99615 (486-5765)

KOTZEBUE: Box 317, Kotzebue, AK 99752 (442-3208)

NOME: Box 100, Nome, AK 99762 (443-5216)

PALMER: Box 860, Palmer, AK 99645 (745-4283)

SITKA: Box 910, Sitka, AK 99835 (747-3291)

WRANGELL: Box 869, Wrangell, AK 99929 (874-2311)

DISTRICT COURT LOCATIONS
WHICH WILL ACCEPT CIVIL COMMITMENT PETITIONS

HOMER: Box 136, Homer, AK 99603 (235-8171)

VALDEZ: Box 127, Valdez, AK 99686 (835-2266)

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